Relationships in therapy: Perspectives of practitioners, carers, and young people affected by child sexual abuse

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Perspectives of practitioners, carers and young people affected by child sexual abuse

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Declaration

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Abstract

The importance of the “therapeutic relationship” in the process of therapeutic change has long been recognised in psychotherapy literature and in recent years has also been evidenced in empirical research. Using a social constructionist framework, this study considers relationships formed in a therapeutic intervention for children and young people affected by child sexual abuse. The intervention is based primarily on a psychodynamic model of recovery informed by trauma, attachment and resilience theories. Based on interviews with six children and young people, seven carers and thirteen practitioners, the thesis explores the individual perspectives of children and young people, their carers and practitioners involved in the intervention. In addition, data collected during the evaluation of the intervention from 85 completed *Carer Feedback Questionnaires* and 148 responses on the *Therapeutic Alliance Scale for Children* (Shirk and Saiz, 1992) is presented.

Perceptions of change within the therapeutic relationship are explored, including participants’ recollections of conversations and events. The thesis examines how children, young people and carers made connections with practitioners, agreed therapeutic goals and activities within the relationship and how they transferred activities and learning beyond the therapy into their everyday spaces. Major themes discussed are confidentiality, trust, safety, choice, power, non-judgmental attitudes and hope for the future. An unanticipated but connected theme links maternal responses to social constructions of “bad” mothers, and highlights the importance for parents of feelings of safety and trust in the practitioner-parent relationship following child sexual abuse. The findings demonstrate the importance for service users of sharing a relational space, and provide insight into the relational processes in therapeutic work with young people and their parents.

Acknowledgements

This project is dedicated to all the young people and families for whom I wish I had been a better social worker.

This thesis is not mine alone and could not have been written without the participation and support of many inspiring and wonderful people. Each of them has at one time or another kept me going when it felt as if I was going nowhere.

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I would also like to thank the Agency involved and everyone who took part in the study, but especially the young people, their parents and carers, and practitioners. Their cooperation, trust, openness and willingness to share sensitive and important information with me provided invaluable rich detail about their relationships, the practice, the emotions and the magic of therapeutic work. This work is dedicated to them, and would not exist without them.

Finally, my family have sustained and encouraged me throughout and I feel enormously indebted to them for their love, patience, sacrifices, support and strength. My parents did not get to see this work finished, but were an inspiration throughout my life and would have been proud. I thank my sister Jane for her humour, love and for doing all the things I should have been doing to help in my absence. I thank Catie for loving support and excellent editing. I thank my sons Sam and James for getting on with their lives and tolerating a student-mother. Finally, I thank my husband Richard who is truly remarkable, remained interested when I lost interest, believed in me when I didn't, and without whom I feel incomplete.

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1 Chapter One Overview: Setting the scene

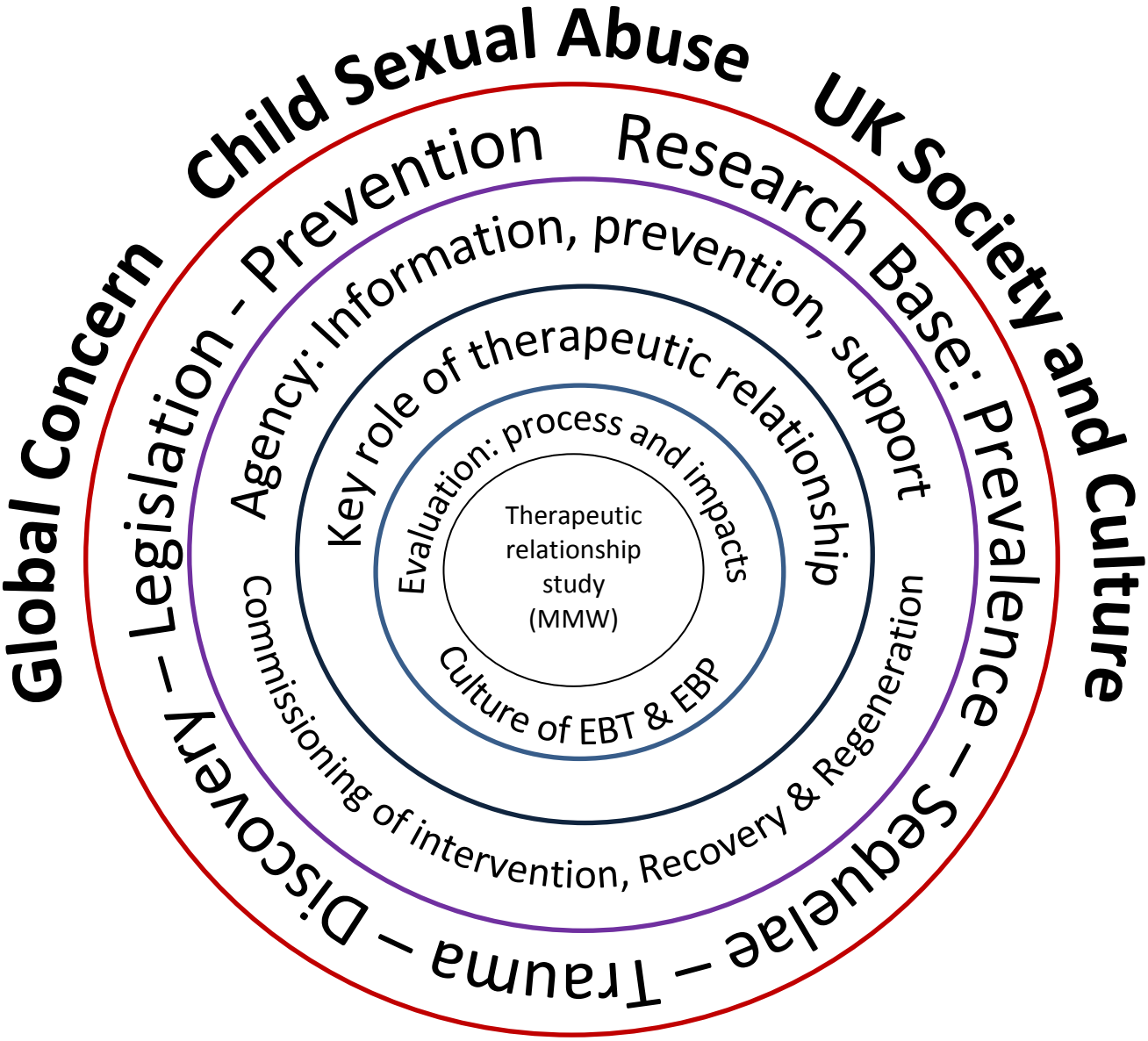
1.1 Introduction

This chapter introduces the context of the thesis and its framework, noting the significance in social life of relationships in general, and relationships in therapeutic encounters in particular. It places the study within the context of a specific agency, a new intervention designed for a particular population, and an evaluation of the intervention. It provides an overview of the thesis structure, introduces the social constructionist framework and my personal interest in the topic, and describes the rationale for studying therapeutic relationships in this context.

The thesis explores therapeutic relationships through the lens of social constructionism and from the position of a woman and experienced social work practitioner. The study was undertaken as part of a process and impact evaluation (Carpenter et al., 2016) of a therapeutic intervention for children and young people affected by sexual abuse. The evaluation was commissioned in 2011 by a children's charity working in England, Wales and Northern Ireland (referred to here as the *'Agency')* and was completed in 2015. The intervention was developed in light of national and international concern with the prevalence of child sexual abuse and exploitation and understanding of the social, cultural and legislative context in relation to sexual offending and consequences for child victims. It represents a response to national focus on prevention and support for survivors. It is an integrative, phased, and structured therapeutic intervention, offered to children and young people aged 4-17, and based on a framework of creative therapy for traumatised children (Bannister, 2003). Central to the intervention's model is the development of a therapeutic relationship between child and therapist, and examination of the relationships developed in therapy forms the focus of this study.

Whilst therapeutic models for children traumatised by sexual abuse have been evaluated, the most rigorous evidence base is in relation to cognitive behaviour therapy (CBT) rather than to psychotherapeutic or creative therapies. The evaluation was designed in the context of current debates about the importance of evidence based practice (EBP). In the evaluation, the study is referred to as the "*therapeutic relationship study"*; it is also known amongst participants as the "*Me and My Worker"* Study *(MMW).* An illustration of the wider framework around the intervention and the evaluation is shown below:

Figure 1: Contextual framework for intervention and evaluation



1.2 The Intervention

The service is offered to children who have been affected by sexual abuse and their carers or parents. Bannister's (2003) model promotes healing from trauma through creative therapies, is underpinned by attachment theory and trauma theory, and advocates the use of techniques appropriate to the child's development, age and needs. The therapeutic aim is recovery from trauma including better understanding of feelings, identity development, and ability to form and maintain good relationships, concepts which resonate with the notion of growth following trauma (Briere and Scott, 2006). The model recognises the part that children play in their own healing process and the contribution of therapist skills and knowledge. The intervention therefore encourages a multi-theoretical approach, which in practice means that whilst practitioners are guided through phases of assessment and intervention, they are free to use methods, theories and approaches best suited to the child's needs. Regardless of approach, the therapeutic relationship is seen as essential to achieving therapeutic change, and therefore is at the heart of the intervention.

The intervention was commissioned following research indicating that availability of services for children who had experienced sexual abuse does not match the estimated need (Allnock et al., 2009; Allnock et al., 2012). Exact numbers of child victims are impossible to obtain due to the difficulties of discovery and disclosure of child sexual abuse, but in the UK it is estimated that approximately five percent of children and young people aged between 11 and 17 have experienced contact sexual abuse during childhood and a substantial proportion do not disclose (Radford et al., 2011). Bentley et al. (2016) reported that data collected from official sources revealed that police in the UK recorded over 47,000 sexual offences against children in 2014-2015.

Included in the intervention is an optional carer service, provided by practitioners not working directly with the child, for non-abusing parents/carers referred to as "safe carers". The carer service is not formally

therapeutic, but is considered important for some parents who require help to support their children during and after therapy. The *Agency* adopts a systemic and ecological view of children's development and recovery from trauma, recognising that children continuously interact with and are influenced by their environment, and that whilst therapy may help resolve trauma, to maintain progress children require a safe and supportive environment. Aims of the carer service include helping parents cope with children's behavioural and emotional responses to abuse, and deal with their own negative emotions. The support of non-abusing carers for children is important to their recovery (Cohen and Mannarino, 1996; Lipton, 1997; Van Toledo and Seymour, 2013), but may be compromised by parents' own responses to their child's abuse. Research and practice-informed evidence demonstrate that parents experience negative impacts including secondary traumatisation upon learning that their child has been sexually abused (Elliot and Carnes, 2001; Deblinger et al., 1993; Clevenger, 2016; Gibney and Jones, 2014; Manion et al., 1996; Tavkar and Hansen, 2011) and that impacts may be greater if the abuser was a family member (Hill, 2001). For some parents or carers, work with practitioners is expected to involve sensitive and emotional issues, and the focus may be 'therapeutic' in the sense of healing and helping. Therefore, this study additionally explores parental relationships with their own workers.

1.3 Evaluating the intervention and the position of the study within the evaluation

The *Agency* committed to an independent impact and implementation evaluation of the intervention by universities of Bristol and Durham, the outcomes of which have been reported (Carpenter et al., 2016). Service providers, commissioners, and service users increasingly demand evidence of a programme's effectiveness before committing to it. The principles of EBP are well established in the United States and the UK. Initiatives which aim to ensure that policy and practice decisions are based on sound evidence confirm the significance of EBP.

The focus on EBP or 'evidence based treatment' (EBT) is not without controversy. The search for scientific evidence begs the question of what kind of evidence is presented, who decides whether it is valid and how it is collected and analysed. In addition, the perceived insistence on objectivity is seen as exclusive and dismissive of service user voices and multiple viewpoints, particularly amongst already marginalised groups. As Glasby and Beresford (2006) argue, the aim to achieve objectivity privileges quantitative methods and designs such as randomised control trials over qualitative methods, despite epistemological questioning of the assumptions that research methods appropriate in medical and natural sciences are equally appropriate to study of people and conditions in social sciences. They challenge the assumption that one type of evidence is better than another and that objectivity is a "*prerequisite for valid evidence"* (Glasby and Beresford, 2006:271) and call instead for an approach they label "*knowledge based practice"* (Glasby and Beresford, 2006:281). Their arguments make a case for using a range of methods rather than just one to ensure that the voices of those for whom the outcomes matter are heard.

Making use of research in practice also raises issues. Practitioners working directly with people may question whether what research says "works" for one child or family will also work for another. Kazdin (2008) makes a distinction and describes the tension between EBP and EBT in psychotherapy practice and research, defining EBT as interventions "*that have produced therapeutic change in controlled trials"* and EBP as referring to:

> "…*clinical practice that is informed by evidence about interventions, clinical expertise, and patient needs, values and preferences and their integration in decision-making about individual care…"* (Kazdin, 2008:147)

Kazdin (2008) explains that debates in research include who decides the outcomes to be measured, what the goals of therapy are and who defines them, whether the methods used in evaluations are appropriate, and what changes on standardised psychological measurement tools actually mean in

individuals' everyday lives. Debates in practice, meanwhile, include professional use of clinical judgement to meet unique individual needs, capacity to generalise amongst cases, challenges of describing success without systematically measuring change, and recognition that clinical judgement about what will work in practice is, as Kazdin (2008) notes, probabilistic. He proposes that the aim of both research and practice is ultimately to improve lives through expanding the knowledge base, and suggests that to move forward research needs to prioritise:

a) Study of *"mechanisms of therapeutic change";*
b) Study of *"moderators of change in ways that can be better translated to clinical practice",* and
c) Qualitative research (Kazdin, 2008:151).

Discussions of the debates and issues around EBT and EBP highlight the value for researchers, practitioners, and service users in combining quantitative and qualitative methods in social care research. Kazdin states that:

> "…*investing narrowly, whether in only one stock for a retirement plan or in a single methodological tradition such as quantitative psychology, invariably bears a cost. Different methods can reveal different facets of a phenomenon."* (Kazdin, 2008: 154)

1.3.1 Evaluating with mixed methods

The evaluation used mixed methods comprising a randomised controlled trial (with a waiting list control group) and qualitative case studies. To examine impact, it posed the following questions:

- What are the outcomes for children and young people affected by sexual abuse who engage with the intervention?
- What is the cost-effectiveness of the intervention?
- What is the effectiveness of the support intervention received by 'safe carers'?

The research team measured outcomes using standardised instruments including the *Trauma Symptoms Checklist for Children* and *Trauma Symptom Checklist for Young Children (TSCC* and *TSCYC)*(Briere, 1996; 2001), and for carers and parents the *Parenting Stress Index (PSI)*(Abidin,

1995). Data was first collected prior to randomisation (T1), and then at six month intervals (T2 and T3).

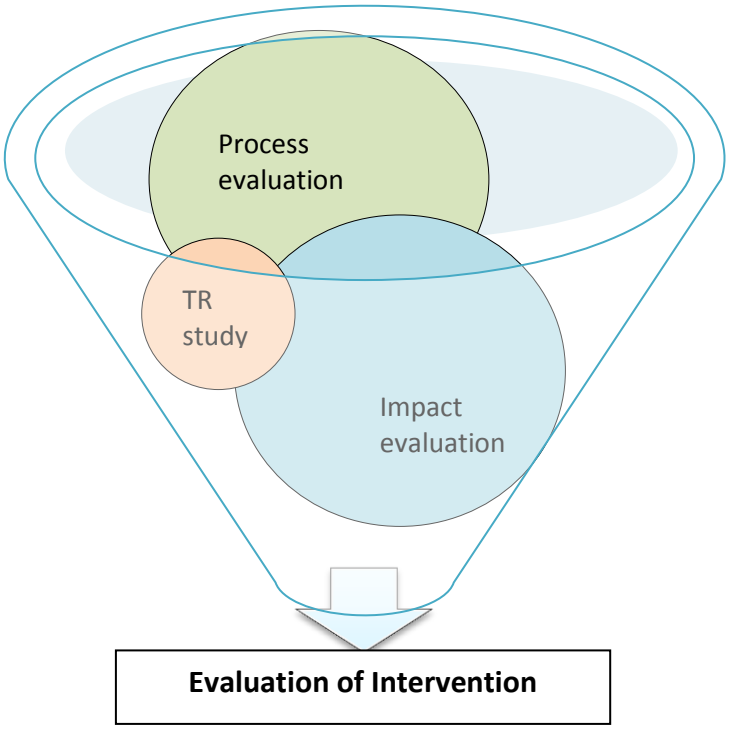
The process evaluation asked:

- How is the intervention delivered?
- What are children's, safe carers' and practitioners experiences and perceptions of the intervention?

The therapeutic relationship study which forms the subject of this thesis is positioned primarily within the process evaluation, and specifically within the broad question of how people experienced the intervention. It overlaps with the impact evaluation in seeking perspectives on changes, and complements both quantitative and qualitative components of the evaluation. The evaluation measured therapeutic alliance between children and therapists twice (T1 and T2) using the *Therapeutic Alliance Scales for Children (TASC)*(Shirk and Saiz, 1992); however, the significance of the therapeutic relationships in the intervention demands closer attention to gain understanding of them from the inside, from the perspectives of service users and practitioners rather than solely as remote observers.

Figure 2 below shows the study of therapeutic relationships in the intervention as a small scale study embedded in the process and impact evaluation.

Figure 2: conceptual framework for the research



As a study contributing to a formal evaluation of the intervention, the research needs to satisfy the requirements of a doctoral course of study and remain accountable to the evaluation team and the intervention stakeholders. This position has benefits and challenges for the researcher. The benefits include access to research sites and participants within an agency which actively promotes research and development, knowledge about the progress of the evaluation, and awareness of issues involved in such a complex project. The evaluation provides contextual and structural parameters for the doctoral research. This situation also poses challenges, however, including the need to fit in with external timescales, and the demand to produce different reports for different audiences. The therapeutic relationship study's research questions are derived from the literature and research about relationships developed in a therapeutic context and the theoretical framework, and at the same time informed by the evaluation's structure and aims.

1.3.2 The contribution of the therapeutic relationship study to the evaluation

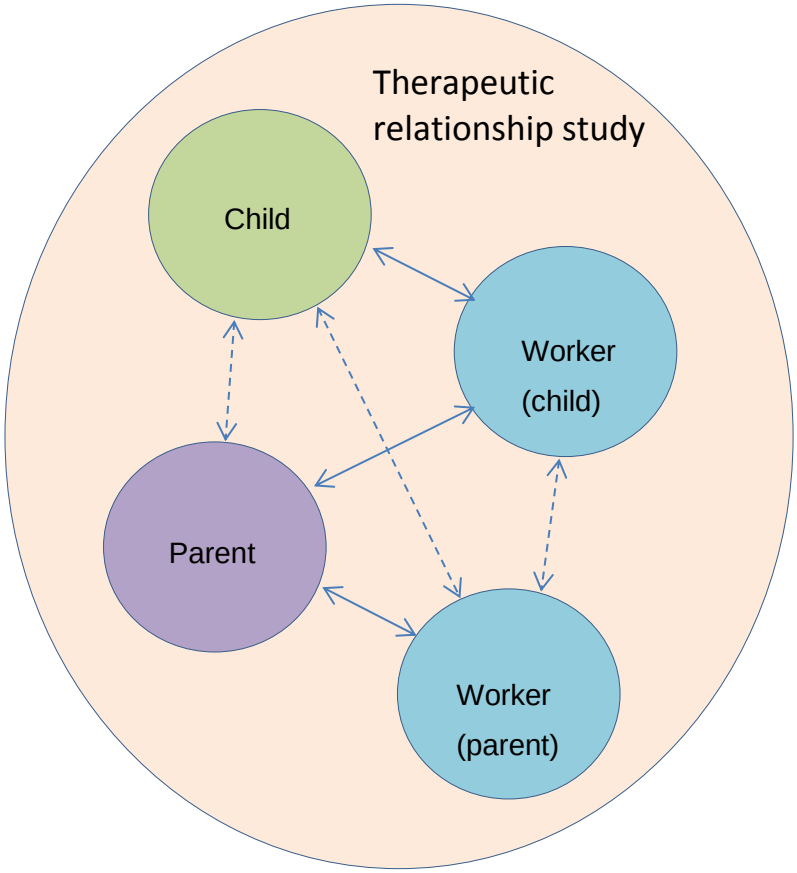
The evaluation measured the strength of therapeutic relationships between children and practitioners using the *TASC*. No scale was used to assess the relationships between carers and their practitioners, although a feedback questionnaire, the *Carer Feedback Questionnaire* (*CFQ*) invited carers to rate aspects of their relationships. The evaluation also gathered qualitative data from families and practitioners who spoke of their experiences of the intervention and referred positively to the relationships they developed. This study differs from evaluation enquiries in its focus on participant perspectives on relational experiences, rather than on experience of the intervention. Further, it specifically addresses the question of how relationships developed between carers and their own practitioners, and the qualities identified in these relationships.

1.3.2.1 Mixed methods in the therapeutic relationship study

The therapeutic relationship study is primarily a qualitative study, inviting participants to provide their perspectives on relationships formed during the intervention in semi-structured interviews. However, the thesis also presents data from a subset of the *TASC* scores collected by the evaluation team. It analyses this data in a different way, incorporating discussion of 'bond' and 'task' scores which make up *TASC* into the chapters which discuss corresponding qualitative data. The decision to use quantitative data was made as the study evolved during the initial planning and design phase. The data is not used to demonstrate links between therapeutic relationship and outcomes, or to compare matched practitioner and child scores at T1 and T2, as these analyses were done in the evaluation. Where relevant, the findings of the final report are referenced. Little CFQ data was included in the evaluation report, however, and both carer comments and scores related to carer rating of the relationship with practitioners are uniquely reported in this study.

Figure 3 below shows the conceptual framework of the therapeutic relationship study itself. The solid lines indicate the relationships being examined. The dotted lines indicate significant relationships about which information comes to light in the course of the study, but which do not represent a focus of the study. The research explores the perspectives of these three groups – children, parents, and practitioners – on the relationships they developed during the time they were together.

Figure 3: conceptual framework for the therapeutic relationship study



1.4 The research questions

The research questions are informed by the overall aims and structure of the evaluation. The questions are formulated to contribute to evaluation of impact – that is, how well the intervention achieves its aims – and also to shed light on the 'therapeutic relationship', a phenomenon which is experienced in the privacy and intimacy of the therapeutic space created by the practitioner and the service user together. Questions focus therefore on finding out what those engaged in the relationships thought and felt about their experiences.

The aims of the research were:

- To complement the aims of the evaluation to explore impact and process and to contribute to the overall findings
- To enhance understanding of the therapeutic relationships between children affected by sexual abuse and their practitioners
- To gain insight into the relationships developed by safe carers with their practitioners in the carer intervention
- To provide service users with an opportunity to give voice to their views on relationships developed in a therapeutic service and their perceived benefits

To accomplish these aims, the study's objective was to find out what the experiences were of the relationships established in this intervention from the perspectives of the people involved. It posed the following questions:

1. From participant perspectives, to what extent do practitioners establish positive therapeutic relationships with children and safe carers?

2. How are the concepts of bond, collaboration on therapeutic tasks and agreement on goals manifested in relationships in this study?

3. How do the therapeutic relationships between children and their practitioners develop and change during the course of the intervention?

4. What child, practitioner and carer characteristics are associated with establishing and maintaining an effective relationship in therapy?

5. What patterns can be observed in the development and maintenance of relationships?

6. What are participants' views on how the relationship helped them change?

1.5 Why study relationships?

> "*As we relate together, so do we construct our future."* (Gergen, 2015: xii)

Relationships help define the social world of individuals. They matter in everyday life, and they matter in therapeutic interventions: clinicians through the years have recognised the negative consequences of experiencing relationships which are abusive or deficient in some other way, and the restorative benefits of relationship in working with people who seek help.

Human identities as individuals and as social actors are constructed by the connections made with others, and by interpretations of how we are viewed and of how we view the world. The relationships developed in therapy have for many years been recognised as a key, if not essential, component of therapeutic interventions, from psychoanalysis to cognitive behavioural programmes. The therapeutic relationship is a social relationship with a particular purpose of solving a problem or changing something in a person's life. The existence of a special kind of relationship within the context of therapy was first described by psychoanalysts (Elvins and Green, 2008; Horvath, 2006; Sanderson, 2006) and has been extended, adopted and redefined by practitioners and theorists in different disciplines through the years (Elvins and Green, 2008; Horvath, 2006; Sanderson, 2006). The past few decades have seen an acceleration of research interest in the nature and processes of relationships in therapies, and a growing body of empirical support for the association between the strength of the therapist-patient relationship and positive therapy outcomes (Cahill et al., 2008; Crits-Christoph et al., 2006, Horvath et al., 2011). It is only fairly recently, however, that research has focused on the nature, quality and association with outcomes of therapeutic relationships with children and young people. A small proportion of this research examines the relationships from the perspectives of the people who form a connection through therapy.

1.6 The language of the therapeutic relationship

Bordin (1979:252) noted in his influential article on the working alliance in therapeutic situations the potential for there to be a "*psychotherapeutic method for each psychotherapist".* Further, psychotherapy is but one of a multitude of therapies on offer: an internet search reveals a range of traditional and less familiar therapies from around the world. Kazdin (2008:150) previously found over 550 adolescent and child therapies and noted that the number was growing. They generally have in common at least one therapy provider or a help-giver, and one or more people seeking therapy. However, just as therapies vary significantly in form, method,

theoretical understanding, and origins, so therapists represent a range of backgrounds, training, motives, and positions. With such variety comes a plethora of terms used to refer to the relationship and the people involved. Therapists may be social workers, counsellors, psychologists, analysts, or nurses. They may be talking, playing, or creating music or art; they may work individually or in groups; they may offer formal or informal sessions frequently or infrequently, over a long or short period of times. In every case, there is a relationship between the person providing the therapy and the person receiving it.

This thesis uses the terms "*therapist", "worker", "counsellor"* and "*practitioner"* interchangeably as research participants did.

Similarly, the terms "*carer"* and "*parent"* are both used to refer to the people caring for children in the study and generally. However, in the introduction to the participants in the qualitative sample (Chapter 5), the relationship as either birth parent or carer is clarified.

The terms "*children"* and "*young people"* are also used interchangeably.

The phrases "*therapeutic relationship*" and "*relationship in therapy"* refer to the relationship between children and their practitioners, and between carers and their practitioners, whether the service offered was defined as therapy or not.

Finally, the intervention is variously referred to as an "*intervention"* or *"therapy",* and the meetings between therapists and young people/carers are described as "*sessions"* or *"meetings"* as they were named by study participants.

1.7 Introducing the social constructionist lens

This thesis adopts a social constructionist view on the therapeutic relationship. Unlike psychodynamic approaches, the social constructionist therapies represent a shift from "*mind*" – described in psychodynamic approaches as the location of change, brought about through interpretation guided by a therapist – to "*discourse"* which occurs in relationships. This is a

view born, as McNamee and Gergen (1992) observe, from the "*unease"* experienced by some therapy providers with a "*traditional view of scientist-therapist"* (McNamee and Gergen, 1992:2). This view, which tends to label individuals seeking help as inadequate in some way and needing help to be able to function, is challenged by constructionist perspectives which see such practices as oppressive, individualistic, and assumptive.

Constructionist views permeate the analysis and discussion, but do not necessarily represent the views of those engaged in the therapy. Constructionism offers another way of looking at how relationships develop and how change occurs, but it neither negates nor challenges how practitioners approached the relationships or the work.

1.8 The reflexive researcher

I have been influenced in this project by my experience as a Local Authority and NSPCC social worker who believes that relationships in practice are important. This thesis represents, as well as a study enhancing understanding of relationships in therapy, an opportunity to gain a different perspective on historical relationships with children and families affected by sexual abuse, some of whom remain imprinted in my memory. How they changed through our relationship I cannot know, but looking back I recognise that I have changed through connecting with them. Memories fade and alter, but I know there were things I did that helped the relationship grow, and many things I could have done to make it better, more equal, and more productive in terms of change. I understand that my beliefs influence every part of this study, and that it is important both to be aware of that influence and to state it openly: to do otherwise would be to betray my integrity, and contradict my social work training, values, and messages that I pass on to social workers in training. Reflexivity underpins my approach to both practice and research as the methodology chapters 3 and 4 emphasise, and is a topic to which I return in Chapter 10.

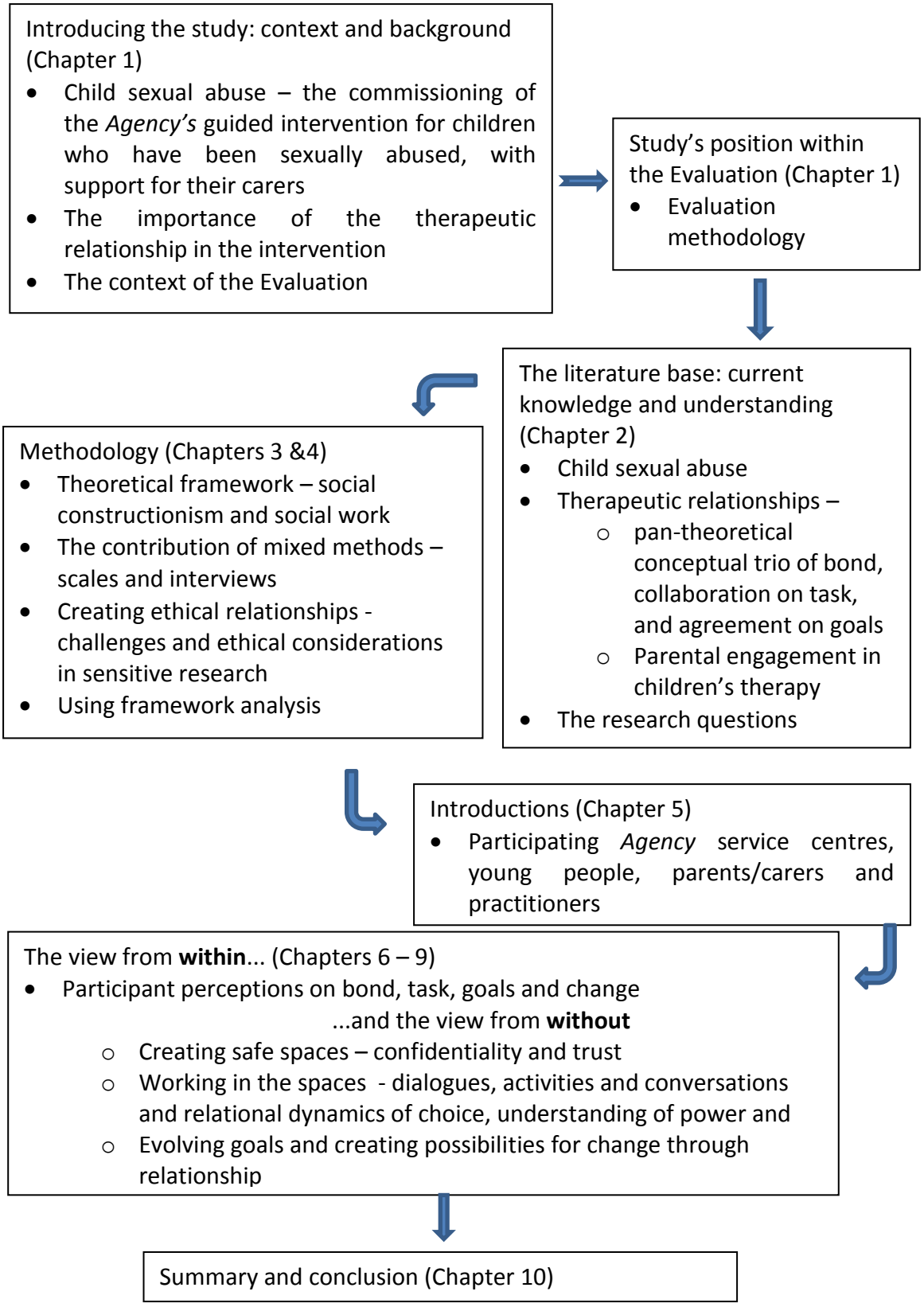
1.9 Overview of thesis structure

This chapter introduced the context of the research as embedded in a process and impact evaluation, posed a rationale for studying therapeutic relationships from participants' perspectives and presented the aims and research questions.

Chapter 2 reviews the literature related to child sexual abuse and therapeutic relationships. Chapters 3 and 4 describe the theoretical framework and methodological approach, restating the research questions, and the methods used to answer the questions. Chapter 5 is a "bridging chapter" – it introduces the qualitative research sites and the participants. Chapters 6 – 9 are findings chapters. As the study aims to gain service user and provider perspectives, findings chapters contain many quotations, representing the voices 'from within' the experience of a relationship in a therapeutic context. The voice 'from without' is the interpretive voice of the researcher. The participants' perspectives are retrospective views, co-constructed with the interviewer, on the experience of "relationship" which is a difficult concept to represent in words. Every effort is made to use the language of participants, and to place quotations in the context of interview conversations. Chapter 6, "Constructing the safe space", describes how young people and carers created with practitioners spaces in which they felt safe enough to work on problems. This chapter corresponds with the concept of creating bonds in therapy, and as a backdrop to the presentation and discussion of findings, outcomes of the *TASC* analysis of the quantitative study sample are discussed as they relate to measuring strength of the bond between children and practitioners. Chapter 7, "Working in the safe space", presents and discusses findings on how young people and carers worked together with practitioners. This chapter coincides with the notion of collaboration on tasks in therapeutic relationships, and includes a section on outcomes of *TASC* analysis, in this case as scores pertain to agreement between young people and practitioners on working on tasks. Chapters 8 and 9 present findings and discussions on goal agreement and

perceptions of change through relationships. The Carer Feedback Questionnaire (*CFQ*) data is presented in Chapter 9. Finally, Chapter 10 offers a conclusion, summary, description of the limitations of the study, reflexions, unique knowledge contribution, and implications for practice and further research. The organisation of material from introduction, through exploration of the literature base, methodology and methods, thematic analysis and conclusions is summarised in the following chart:

Figure 4: Overview of thesis structure



2 Chapter Two: Review of the literature

2.1 Introduction

There are two literature strands relevant to this thesis: child sexual abuse (CSA), and therapeutic relationships (TR). Part 1 of this chapter presents an historical overview of CSA and discusses challenges in defining CSA and the current understanding, research, and responses. It notes the changing awareness of sexual offending, the developing knowledge base around those who perpetrate and those who experience CSA, and the shifting cultural, social and political environment in which the intervention developed. It describes impacts of CSA and presents research findings related to interventions for children presenting with symptoms identified with CSA.

Part 2 reviews the literature on therapeutic relationships. It provides definitions and different perspectives on the relationships between therapists and their clients; helpers and help-seekers. It charts the emergence of a knowledge base about therapeutic relationships in child and young people populations, tracks the development of scales to measure the strength of the relationship, and presents the evidence base relating strength of relationships to outcomes of treatment for children who have experienced sexual abuse.

2.2 Part 1: Child Sexual Abuse

2.2.1 Child sexual abuse: the ultimate 'boo-word'

> *"The importance of definitional clarity derives most obviously from the fact that the term 'child abuse' has enormous evaluation force. It commands a moral response, one of unequivocal condemnation. What it designates is something that is plainly wrong. The term is thus what ordinary language philosophers used to characterize as a pejorative or 'boo-word'."* (Archard, 1999:74)

The term 'child sexual abuse' is emotive. For survivors it may trigger painful memories; for parents a complex array of emotions of dread, protectiveness, anxiety and avoidance; for abusers a range of feelings around guilt and arousal. Sexual abuse is simultaneously personal and intimate and also of

great public concern because of the harm it causes. Quoting Gough (1996:996), Archard writes that the concept of child abuse which causes harm is different from the kind of accidental harm which occurs in children's lives because abuse is attributable to *"human agency. 'The two basic concepts underlying all definitions of abuse are harm and responsibility for that harm'."* (Archard, 1999:76)

It has proved difficult to provide a fixed and precise definition of CSA (Goldman and Padayachi, 2000) or in fact child abuse in general, in part because in the scale of social history it is a relatively "modern" concept (Archard, 1999; Corby, 2007). Dispute about basic elements of CSA – which acts count as "sex", which of those sexual acts are "abusive" and what age is a "child" – are common. Definitions of abuse are tied up with definitions of child and childhood, but debates and controversy associated with sex and sexual acts are not limited to sexual abuse of children. CSA in Britain was not, as Corby (2007:32) notes "*high on the agenda"* throughout the first half of the twentieth century although incest was recognised as an offence and child care organisations believed it caused harm and treated it seriously. Explanations about the "battered baby" – what Corby refers to as the "*rediscovery of child abuse"* (Corby, 2007:36) – propelled child abuse into the public arena, but it was not until the 1980's in the UK that CSA began to be recognised as a distinct and troublesome form of abuse. The process of rediscovery, or "reconstruction" of deliberate harm to children as resulting from "abuse", and the "malleability" of child abuse definitions (Archard, 1999:82) are discussed in the next section.

2.2.2 What is child sexual abuse?

2.2.2.1 Historical overview and emergence of a social problem

An older relative of mine used to give responses to news items about CSA varying only in phrasing around the observation that "*it didn't happen in my day."* Yet over the years, she began to consider the possibility that "*it*" did happen in her day, only in the world she knew it was not defined as abuse, was not thought to cause any harm, was not widespread or serious enough

to be of concern, or was known but never talked about. As time went on, her views changed perhaps as a result of our conversations, but also in line with popular views as the public experienced increasing exposure to stories from the media, survivors, researchers, practitioners, politicians and campaigners in the UK and abroad.

The perception that CSA was uncovered in the 1970's and 1980's is belied by knowledge of the NSPCC's involvement with issues of CSA in the family over 100 years ago (Corby, 2007; Kelly, 2002; McAlinden, 2007). Recorded knowledge preceded that date by about a century, but existed in a climate of confusion and controversy. Sexual abuse in the family was a taboo idea, so remained hidden. Explanations at the time for familial sexual abuse included that it was linked to poverty, and possibly fuelled by drink (Corby, 2007:28) so did not concern the rest of the population. Conversely, child prostitution, which occurred outside the family, was openly discussed, as evidenced by the Victorian legislation (Criminal Law Amendment Act, 1885) raising the age of consent to sexual intercourse for girls from 13 to 16. The law did little to address the problems of prostitution and ignored underlying causes, but highlighted awareness that the activity was considered problematic.

2.2.2.2 Definitional difficulties

Sources agree that the widespread focus on CSA began in the 1970's, and that research from the USA initially predominated (Goldman and Padayachi, 2000; Haugaard, 2000; Stoltenborgh et al., 2011). Contributors to the knowledge base include professionals from a range of disciplines so it is unsurprising that a common definition has remained elusive. Psychologists and medical researchers hoping for consensus on a definition which can be conveniently operationalised have been frustrated, as Haugaard (2000:1036) says: "*Each word in the term child sexual abuse has been operationalized differently by different researchers."* The report *Understanding Child Abuse and Neglect* states that:

> *"A basic requirement for scientific progress on research on child maltreatment is the availability of authoritative, valid and operational measures of child abuse and neglect."* (Panel for Research on Child Abuse and Neglect, 1993:59)

The emphasis on "scientific progress" reveals an aim to pursue scientific inquiry in relation to CSA, suggesting objectivity, the methodological rigor of positivist approaches, and usually quantitative methods. To achieve validity and consistency it would appear necessary to agree on a universal meaning for the terms used. On the other hand, there are arguments for leaving room for interpretation in defining such an emotive and complex phenomenon: as Gough (1996) says, a "*lack of specificity allows everyone to be against abuse"* and paves the way for flexibility in interpretation and practical application of results in interventions and policies (Gough, 1996: 994). There is an associated risk however, that flexibility might result in differential responses and interventions.

The debate about clear definitions extends beyond the world of scientific inquiry and the need to determine incidence, prevalence, risk factors and harm. In the real world of child abuse, children, parents, and professionals supporting and making decisions about children's lives prefer to be able to name what they are working with. Working definitions are necessary to ensure consistency, common standards and informed decision-making. However the experienced reality for children and individuals close to them may seem significantly removed from the terms used in research, courts, and practice/policy arenas, and is affected by context, culture differences, prevailing social discourses and standpoint. What Archard (1999) describes as "*orthodox"* definitions, those that appear in practice, research and policy documents are likely to differ from "*persuasive"* definitions, which arise when individuals or groups attempt to convince others that something additional should be incorporated into the existing concept. Archard describes this process as extending the scope of the "*boo-word"* (Archard, 1999:81).

2.2.2.3 Representations of CSA in the media

It is important in discussing definitions of CSA to reference the impact of the public scrutiny and the media on society's understanding of sexual offending and victims/survivors (Lefevre, 2010). Media and government responses to child abuse in general are linked through, for example, reporting and commenting on public inquiries into child deaths (Laming Report on the death of Victoria Climbié, January, 2003) and child sexual abuse (DHSS, 1988, *Report of the Inquiry into Child Abuse in Cleveland).* These inquiries led to changes in policy and practice and two significant pieces of legislation: the Children Act 1989, and the *Every Child Matters* agenda and Children Act 2004 (Davidson, 2008: 44). High profile public inquiries and cases such as the murder of Sarah Payne in 2000 have been credited with contributing to the current *"'moral panic' regarding the incidence and nature of child abuse"* (Davidson, 2008:36). Media responses to child murders and sexual abuse in the UK and the USA may be seen as representing parents' worst fears for their children (Davidson, 2008; Jenkins, 1998). There is little doubt that child sexual abusers are seen to fall into the category of "demons", and provocative and indiscriminate use of terms such as 'paedophile', 'evil', 'perv', and 'monster' (Davidson, 2008) found in many tabloid newspapers risks inflaming rather than informing the public. The media

> *"...have contributed to the creation of a myth, which has been readily absorbed by the public, that society is full of sexual predators known to the authorities who are ready to prey on the vulnerable, in particular women and young children who were previously unknown to them."* (McAlinden, 2007:11)

Definitions of abuse and offending are further complicated by associated moral and political discourses about vulnerability and victimhood (McAlinden, 2014). Social constructions of victims and vulnerable groups, what McAlinden refers to as "*an undifferentiated and abstract class of generic or potential victims"* (McAlinden, 2014:181) are relevant to the social identities which young people bring to their therapy. The status of children and their protection in the moral crisis remains at times ambiguous. Media

representations in cases such as Adam Johnson's, the Sunderland footballer, whose public trial for grooming and sexual contact with a 15-year-old girl evoked much debate (see e.g. Curtis, 2016; Spillet, 2016) demonstrate the fractures in polarising arguments that all child victims are innocent and "good" and all child molesters are blameworthy and "bad". Against such a background, the difficulty of arriving at a mutually agreed definition of CSA is clear.

2.2.3 Definitions of child sexual abuse

CSA has been variously defined in policy and literature (Macdonald et al., 2012). The World Health Organisation guidance (Butchart et al., 2006) defines sexual abuse as:

> *"…the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared, or else that violates the laws or social taboos of society. Children can be sexually abused by both adults and other children who are – by virtue of their age or stage of development – in a position of responsibility, trust or power over the victim." (Butchart et al, 2006:10)*

Sexual offences and the penalties for sexually abusing children in the UK are described by the Sexual Offences Act 2003 (SOA 2003). Whilst sixteen is the legal age of consent to sexual acts, in the UK a child is someone under the age of 18, in accordance with Article 1 of the 1989 UN Convention on the Rights of the Child. Both the Children Acts of 1989 and 2004 recognise children under 18 as in need of legal protection. The concept of informed consent is crucial in determining whether a sexual act is abusive (Finkelhor, 1979). Western society's "sexual ethic" determines that sex is consensual, and children are developmentally incapable of consenting (Finkelhor, 1979:694; Finkelhor and Browne, 1985). Legal and moral decisions relating to sexual abuse are complicated because whilst any sexual activity between an adult (over 18) and a pre-pubertal child is morally indefensible and illegal because the child is unable to consent (Finkelhor,

1979), it may be argued that sex between mutually agreeing 15-year-olds who are below the age of consent is consensual; sex between 17-year-olds where one is not consenting is classed as abusive; sexual abuse perpetrated by a 14-year-old against a 16-year-old is a criminal offence if proved even though the perpetrator is below the age of consent for the act with which he or she is charged. That such contradictions exist illustrates the diverse and sometimes contradictory social images of childhood and sexuality. The Sexual Offences Act 2003 (SOA) attempts to resolve some of these issues with distinct offences and penalties depending on age and vulnerability and the addition of new offences, and has established 13 as the age below which children are unable to give informed consent.

The definition of CSA has changed considerably over the last 30 years, developing a more *"inclusive understanding"* (Collin-Vézina et al, 2013:1). The language associated with CSA in general has altered, reflecting the developing knowledge base, increasing research, advancing practical expertise, and social and political agendas, and illustrated in Goldman and Padayachi's (2000) discussion of methodological problems associated with CSA research.

In their analysis of the development of the protectionist discourse on child sexual abuse (Stainton Rogers and Stainton Rogers, 1999) the authors note changing perspectives on adult-child sex from an activity portrayed as fairly harmless "*fondling"*, often initiated by the child and "*not likely to impair a child's emotional development"* (West, 1967:195, cited in Stainton Rogers and Stainton Rogers, 1999:183) to a stark account of CSA having a long term impact which "*permeates everything"* (Bass and Davis, 1988:33, cited in Stainton Rogers and Stainton Rogers, 1999:183). Their discussion supports the claim that CSA is socially constructed and that discourses around sex and children/young people are historically and currently complex. It challenges the medical discourse which presents a vision that, as Parton et al. (1997) note, tends to "*suggest child abuse is something that can be unproblematically defined and identified"* (Parton et al., 1997:89). It

resonates with arguments that CSA is different from other forms of abuse: more difficult to discover, more difficult to diagnose, more difficult to investigate. From the child's view point, these differences are translated to more difficult to disclose, more difficult to be believed, more difficult to talk about. CSA is imbued with secrecy, is intimate, and represents abuse of power.

2.2.4 Child sexual exploitation: A form of CSA

Recent research, policy and practice have distinguished child sexual exploitation (CSE) from CSA, defining CSE as a form of CSA. Mitchell et al. (2017) in their research review noted definitional issues including "*differentiating sexual exploitation as a specific concept within child sexual abuse*" (Mitchell et al., 2017:5) suggesting that reaching consensus on a definition of CSE is perhaps no more straightforward than it is for CSA.

The 2017 Core Guidance document for professionals and parents (DFE, 2017) updates previous safeguarding children guidance relating to CSE (DSCF, 2009). The latest government definition of child sexual exploitation therefore is as follows:

> *Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology.* (DFE, 2017:5)

The essence of the new definition is the same as previous versions in that it emphasises power imbalance between exploiter and young person under the age of 18 in the exchange of sexual activity for "something" – *"e.g. food accommodation, drugs, alcohol, cigarettes, affection, gifts, money*" (DfCSF,

2009), and includes recognition that *"violence, coercion and intimidation are common"* (DfCSF, 2009:9). What the new definition alludes to and the previous one makes explicit is the understanding of

> *"…involvement in exploitative relationships being characterised in the main by the child or young person's limited availability of choice resulting from their social/economic and/or emotional vulnerability."* (DfCSF, 2009:9)

Detailed exploration of the complex issues informing different understandings of CSE and impacts on practice is beyond the scope of this thesis, but noting them is important. Arguably all sexual abuse of children is exploitative because regardless of the manner, extent and circumstances of the abuse, it involves the use of power to commit sexual acts without consent. Identifying and defining CSE encounter problems particularly in relation to adolescent sexual activity and issues of consent. What appears to differentiate CSA from CSE in the literature is more explicit understanding of the power of persuasion and the concept of '*exchange*' for young people performing, or having others perform on them, sexual activity. Abuse occurring in the context of young people's involvement in the commercial sex market and in gangs, groups, and trafficking (Berelowitz et al., 2013), are considered to be more appropriately located in the landscape of CSE rather than the broader category of CSA, although as Pitts (2013:24) notes this landscape is sometimes characterised by "*fuzzy-mindedness"*. Because these activities are not restricted to children and young people, the definitions of CSE also intersect with wider definitions of sexual exploitation and human trafficking (Mitchell et al., 2017), with understandings of how children and young people are exploited in the "*wider sex industry*" (Coy, 2016:574) and with recognition of the significance of "*youthfulness"* as an *"important commodity in the sex industry"* (Melrose, 2013:16) and in western culture in general.

The concept of exchange may give young people an illusion of free choice. However, the consequence in practice and in policy of imagining that sexually exploited young people have unlimited choices plays into

discourses which individualise problems, ignore the social, economic and political contexts of both sexual exploitation and constructions of child, childhood and "*female"* childhood, and engage in victim blaming (Melrose, 2013; Pitt, 2013). Pearce (2013) offers a social model of *"abused consent"* which helps reframe the concept of choice in analysing the social context of young people's perceptions of consent in exploitative relationships.

Highlighting differences in definitions of CSA and CSE has relevance for exploring what young people might bring to relationships with therapists, and how therapists respond. For young people who see their exploitative relationships as consensual, engaging with professionals who view their relationships differently or lack training in CSE presents a challenge. For therapists, the first challenge may be accepting the young person's reality and understanding her experiences. For young people, the challenge is to engage with someone whom they don't really see the point of meeting.

2.2.5 Influence of feminist perspectives on child sexual abuse

Feminist campaigners have had significant influence on public and professional attitudes towards sexual abuse in general, including CSA. The assertion that sexual abuse is a gendered issue about power and violence and most often directed against women stems from theories related to male dominance and "*institutionalised male power"* (Corby, 2007:175). Kelly (1988) argues that incest had become synonymous with sexual abuse, that CSA would be better represented along a continuum of abusive experiences, and that public figures and the media are prone to misrepresenting and misusing what research there is, distorting the gendered nature of male abuse of power in child sexual abuse which is *"further amplified when the adult is the girl's father"* (Kelly, 1988:72). Eighteen years later her point about the misuse of CSA research and prevalence data is evidenced again in Andrea Leadsom's recent public claim that it is "*sensible"* not to hire men as nannies because they may be paedophiles (Simons, 2016).

Kelly's recounting of the everyday experiences of girls' unwanted, sexual encounters with men and male peers, by which they felt "*threatened and distressed"* (Kelly, 1988:69) illustrates the impact that even single abusive incidents can have on the survivor's life. This interpretation is crucial to understanding the narratives and emotional turmoil of survivors of historical abuse, as the Jimmy Savile scandal has illustrated. Dominelli (1989) also focused on the abuse of male power in incest and the betrayal of trust inherent in sexual abuse by people known to children, defining incest as being "*about sexualized power relationships through which the coercive imposition of male gratification and interests upon women and children is enacted*" (Dominelli, 1989:298). Where adult power over children is not *"tempered by trust*" the child's safety within the family becomes a "*sham*" (Dominelli, 1989:298).

Like Kelly, Dominelli (1989) notes the absence of children's voices in much of the research, policy and practice with sexually abused children, and the need to challenge the assumptions of the sanctity of family relations and expand definitions of CSA beyond their psychoanalytic origins to incorporate concepts of power and male domination. Dominelli also observes that constructs of childhood which define all children as vulnerable and innocent can reinforce their position of relative powerlessness. Such approaches view incest as a socially constructed phenomenon, a perspective which challenged the idea that incest required blood ties – a notion which has since been incorporated into law and policy so that current conceptions of incest are represented by the term intra-familial abuse or child sexual abuse within the family environment (Horvath et al., 2014).

Whatever origins and perpetuating factors are attributed to CSA, the legal and moral responsibility for acts of sexual abuse lies with the abuser. CSA is real to children and their families who are likely to be affected by varying definitions insofar as they influence the responses of society and professionals and routes to justice and accessibility of help. The next section explores the prevalence and issues related to determining rates of CSA,

research on impacts of CSA, and the range of available therapeutic interventions.

2.2.6 Prevalence

That CSA exists cannot be denied or ignored, although it is difficult to determine precisely how many children are sexually abused. Both incidence and prevalence studies are challenged by methodological limitations (Collin-Vézina et al, 2013; Goldman and Padayachi, 2000; Pereda et al, 2009). Early studies particularly may have been affected by inconsistencies in reporting as well by the recognised barriers to disclosure (Summit, 1983; Collin-Vézina et al, 2013) as both general public and professionals remained unaware of the precise dimensions of child sexual abuse and possible avenues to health and/or justice. Contrary to historical assumptions that CSA was associated with poverty and poor education, current research demonstrates that CSA transgresses class, socio-economic status and ethnic boundaries (Putnam, 2003; Finkelhor, 1993), and incidents of CSA are likely to be under-reported (Goldman and Padayachi, 2000; Pereda et al, 2009). Whilst adult carers may believe that children would report sexual abuse, Summit's (1973) analysis of children's accommodation of their abuse illuminates the reality of the power of the secret and the relative helplessness of the child.

Research describes CSA to be of global concern (Collin-Vézina et al, 2013; Stoltenborgh et al, 2011). Stoltenborgh's et al. (2011) comprehensive meta-analysis spanned nearly three decades from 1980 to 2008 and reviewed over 200 publications. The findings supported views expressed in much of the prevailing literature and practice experience that more girls are abused than boys. Pereda et al (2009), in another meta-analysis, also found a significant gender difference, and noted the only other significant moderator to be the continent under study. Africa reported the highest prevalence and Europe the lowest; Great Britain, represented by a total of six studies, reported a mean prevalence rate of 9.4 for men and 18.2 for women.

In 2010-2011, police in England and Wales recorded 17,727 sexual crimes against children under 16, and over 23,000 sexual offences against children and young people under the age of 18 (NSPCC). Radford et al. (2011) estimated that one in twenty children in the UK had been sexually abused. Because the phenomenon is complex and pervaded by secrecy, it is possible to accept both evidence that CSA referrals are decreasing (Jones et al., 2001) and that society and concerned professionals witness only the "tip of the iceberg" (Bacon, 2008:215). Recognition, assessment, and intervention strategies are complicated by evidence that children may experience more than one form of maltreatment (Finkelhor, 2007a; Finkelhor, 2009). The literature indicates that CSA takes many forms and is not limited to contact offences (Bentovim, 1988b; Berliner, 2011), that sexual behaviour which does not include violence is nevertheless harmful (Berliner, 2011), that boys as well as girls are abused (Holmes and Slap, 1998), that young people can be perpetrators of sexual abuse (Becker, 1998; Hackett et al., 2005; Masson, 1995) and that women as well as men abuse children (Ford, 2006).

The Children's Commissioner's inquiry into child sexual abuse in the family environment estimated that in the two-year period ending March 2014 there were between 400,000-450,000 CSA victims in England (Children's Commissioner Inquiry, Executive Summary 2015:3). Bentley et al. (2016) carried out a comprehensive overview of child protection in the UK. Using collected annual police force figures, they reported in 2014-15 47,000 sexual offences against children under the age of 18 in the UK, and 39,988 in England alone, representing 3.4 sexual offences for every 1000 children under the age of 18 (Bentley et al., 2016:29). Breaking down the offences in England by category for children under 16 revealed 17,534 contact offences (rape and sexual assault), and 12,512 offences of sexual activity with a child under the age of 13 or under the age of 16. Of the contact offences, just over 76 percent of the victims were girls. The figures show a rising trend (Bentley et al., 2016), an increase which could be interpreted as representing an

increase in offences alone. The explanation is likely to be more complex, and indicate a combination of factors including greater public awareness due to high profile investigations, and greater reporting of offences, both current and historical. Bentley et al. (2016) lend some support to this premise in their reporting on UK surveys of public awareness of child abuse and neglect prevalence, in which they noted that 58 percent of the population in the most recent survey believe that abuse and neglect were common.

Children are most often abused by someone in the family or someone they know (Berliner, 2011; Finkelhor et al., 2009). More females are abused than males, although statistics on this finding may be complicated by knowledge that boys are less likely to disclose abuse than girls (Holmes and Slap, 1998; Putnam, 2003). Alaggia & Mishna (2014) in the USA cite estimates of incidence of CSA amongst boys to be as high as 26 percent in the community and 36 percent in clinical samples.

Prosecution for offences of CSA in the UK remains problematic. Child sex offences are subject to the same basic evidentiary rules and regulations as other offences, requiring proof beyond a reasonable doubt. In respect of CSA the criminal justice system is "*disclosure-led"* (Children's Commissioner Report, 2015:7), which given the difficulties children experience in disclosure operates as a barrier to access to justice. Despite legislative changes and guidance designed to remove obstacles for children giving evidence as vulnerable witnesses (Youth Justice and Criminal Evidence Act, 1999), there remain questions about how well the system works with young witnesses who have been sexually abused. The research and discussion is beyond the scope of this paper, but the issue is important to note because for many sexually abused children, involvement in criminal justice processes represents an additional source of stress for them and their families.

2.2.7 Child Sexual Abuse: Impacts

> *"Child sexual abuse needs to be recognized as a serious problem of childhood, if only for the immediate pain, confusion, and upset that can ensue."* (Browne and Finkelhor, 1986)

CSA has the potential to cause "*initial*" harmful effects (Browne and Finklehor, 1986:66) as well as long term consequences. Studies reporting impacts of CSA are now well represented in the literature (Browne and Finkelhor 1986; Finkelhor and Browne, 1985; Goodyear-Brown et al., 2012; Jones and Ramachandani, 1999; Kendall-Tackett et al., 1993; Paolucci et al., 2001). Research, clinical experience, and personal accounts by survivors have also revealed that the effects of CSA can be serious, damaging, and persist into adulthood (Briere and Scott, 2006; Herman, 1992; Paolucci et al., 2001; Sanderson, 2006). The harmful effects vary for individuals, with some children showing no long-term adverse consequences as adults (Finklehor et al., 1990), but others demonstrating lasting emotional, physical, psychological, social, and developmental impacts. Psychosocial effects include sleep difficulties, somatic complaints, eating disturbances, feelings of guilt, shame, fear and anger, and loss of trust (Browne and Finkelhor, 1986; Goelitz and Stewart-Kahn, 2013; Goodyear-Brown et al., 2012). Among the most commonly cited negative outcomes for CSA survivors are Post-Traumatic Stress Disorder (*PTSD*), fear and anxiety, mental health problems including depression, behaviour disorders, sexualised behaviour and self-esteem issues (Avery et al., 2000; Berliner and Saunders, 1996; Briere et al., 2001; Browne and Finkelhor, 1986; Fergusson et al., 2008; Kendall-Tackett et al., 1993; Putnam, 2003; Widom, 1999). PTSD associated with CSA has been found to adversely affect quality of life, with the potential for better life experiences following successful interventions (Gospodarevskaya, 2013). An alternative to PTSD explanations of CSA impacts and symptoms was proposed by Finkelhor and Browne (1985; Finkelhor, 1987). In tracing the application of PTSD to children experiencing sexual abuse, Finkelhor and Browne suggested that there were clusters of impacts specific to CSA, which differentiated it from other sources of childhood trauma, and from adult trauma. They found that PTSD did not account for all the symptoms related to CSA or apply to all cases, and was lacking the clear theoretical underpinning to explain how the diagnosis fit the problem. They suggested the difference in presentation of symptoms amongst sexually victimised

children falling outside the usual PTSD diagnosis *"reflect a trauma that may share elements with PTSD, but is qualitatively different"* (Finkelhor, 1987:351).

Their alternative explanation is the "*Traumagenic Dynamics Model of Child Sexual Abuse"* (Finkelhor and Browne, 1985; Finkelhor, 1987). Traumagenic dynamics are defined as trauma-causing experiences which distort how children view themselves and their worlds (Finkelhor, 1987) and the strategies children develop to cope with these distortions as representing the symptoms observed by others. The Traumagenic Dynamics Model can be viewed as a relational model in which the abusive relationship changes the child's perspective on social relationships, and challenges therapists hoping to rebalance the child's relational perspective. Of particular note is the dynamic of betrayal, defined by Freyd (1996:9) as "*the violation of implicit or explicit trust*". As most CSA is perpetrated by people known to children, the concept of betrayal and the consequent loss of trust in others are significant in considering children's social relationships with other people (Alaggia and Mishna, 2014). In addition, betrayal includes the feeling of being tricked, manipulated or lied to (Finkelhor, 1987; Goelitz and Stewart-Kahn, 2013) leading children to question their own capacity to judge whether another person is safe and trustworthy. For sexually abused children, the sense of betrayal extends to non-abusing family members and beyond, as younger children particularly are likely to believe that trusted adult carers must have known what was happening. As Freyd says: the "*closer and more necessary the relationship, the greater the degree of betrayal"* (Freyd, 1996:9).

There are numerous familial, individual, and environmental factors known to affect a child's response to experience of sexual abuse (Finkelhor and Berliner, 1995). The nature, severity and duration of the abuse are mediating factors, as are protective factors in the family, environment or individual which can also encourage disclosure (Alexander, 1992; Hershkowitz et al., 2007; Widom, 1999). As well as experiencing multiple types of abuse (Finklehor, 2007) children also are known to have multiple CSA experiences.

Children with an initial maltreatment report of CSA who have been "revictimized" (any type of maltreatment) are likely to have more negative outcomes (Oshima et al., 2014). Parental responses to a child's disclosure of CSA can impact upon children's recovery processes both with and without intervention (Avery et al., 1998; Bacon, 2008). Previous maltreatment and a history of mental health or psychological problems tend to predict more severe impacts of abuse (Berliner, 2011). Symptoms among sexually abused children generally improve over time but not in all cases, as research indicates that between 10-24 percent of children fail to improve, or deteriorate (Berliner, 2011; Kendall-Tackett et al., 1993). Some children appear to develop no symptoms or to recover without intervention (Finkelhor and Berliner, 1995; Putnam, 2003).

The explanations for impacts and symptom development of *PTSD*, *Traumagenic Dynamics* (Finkelhor and Browne, 1985) and DESNOS – "*Disorders of Extreme Stress Not Otherwise Specified*" (Putnam, 2003) – are informed by trauma theory. Trauma involves an event or events which involve actual or threatened death or serious injury and associated powerlessness or loss of control, the experience of which results in a variety of responses including the breakdown of the ability to integrate or process what is happening (Gil, 2006:5). The context and meaning of the traumatic event for the child is important, and what may be traumatising to one child may not affect another. Post-traumatic stress, *"the level of trauma symptoms displayed"* which include "*persistent symptoms of heightened arousal, re-experiencing of the traumatizing incident, and numbing of responsiveness"* (Avery et al., 2000: 22) is often measured using a trauma checklist of symptoms such as the *TSCC* (see Chapter 1, section 1.3.1)

2.2.8 Child Sexual Abuse: Impacts on parents/carers

Whether CSA occurs within (intrafamilial) or outside (extrafamilial) the family, the impacts extend beyond those experienced by the victims alone. Much of the research and practice focus however has been on assessing family functioning and parental capacity in order to determine contributory factors

to the abuse or to ensure children are safe. Less attention has been paid to assessment of parental needs following their child's abuse (Prior et al., 1999). Studies have found distress and trauma in parents following CSA disclosure (Davies, 1995; Forbes et al., 2003; Manion et al, 1996). Longer-term effects need further research (Dyb et al, 2003), and improved strategies to support families in crisis have been called for (Gibney and Jones, 2014). Families in which CSA is an issue often present complex dynamics and determining cause and effect is not clear-cut. Systemic responses to CSA risk confounding precipitating and consequential family factors if care is not taken to assess and work sensitively with parents or carers, as support from child welfare agencies is often experienced as stigmatising and may be refused (Parton et al., 1997). Jones and Ramchandani (1999) reported that once a child had been identified as a CSA victim and carers assessed as safe, the multi-agency response tended to fade unless there was an identified role for other professionals to play. If children require no immediate intervention following sexual abuse, non-abusing parental feelings and needs may be overlooked. Such omissions may contribute to delays in the child's recovery and the re-building of bonds within the family (Elliot and Carnes, 2001). Van Toledo and Seymour (2013) cite parental need for personal support and comfort, information, and assistance in dealing with own victimisation and children's behaviour following abuse, and note beneficial interventions offered to non-abusing parents.

Impact studies of non-abusing caregivers reveal emotional distress and stress in the immediate aftermath of CSA disclosure and in the long-term (van Toledo and Seymour, 2013). Denial and disbelief are common but carers have been found to be more likely than not to believe children's disclosures (Elliot and Carnes, 2001). Practitioners are described as generally underestimating the negative effects on non-abusing mothers including loss, emotional distress, and family disruption (Hill, 2001).

Much early research focused on negative images of mothers of sexually-abused children (Deblinger et al, 1993), and perhaps because studies were

mostly about abuse within the family, ignored impacts on fathers. More recent research shows that non-abusing fathers also experience distress and PTSD symptoms following disclosure (van Toledo and Seymour, 2013). Much early debate was polarised around whether or not mothers knew of the abuse, believed their child, colluded or protected. Some discussions on the position of mothers in CSA relate to social constructions of family roles and the concept of "familialism" (Dominelli, 2005:1125, citing Segal, 1983), incorporating idealised notions of 'normal' families as "*white middle-class heterosexual nuclear"* families. "Good" mothers are characterised as "*consistent loving carers"* and as prioritising parenting over everything else. Hooper and Humphreys (1998: 567) argue that within what they describe as the "*family systems orthodoxy",* narratives of collusion, failed responsibility, and physical absence equated with failure to protect, serve to place blame on the mothers of children abused within the family. Deblinger et al. (1993) pointed out that few claims of collusiveness were backed up with empirical research, and suggested that some mothers' inability to support their children stemmed from their own distress rather than from irresponsibility and collusion, and preferred to redefine mothers as secondary victims of abuse (Deblinger et al., 1993: 166).

Studies exist which focus on non-abusing parents' responses to children's disclosures rather than on parental capacity to protect (Clevenger, 2015; Knott, 2012; Manion, 1996; Mclaren, 2013). Research reveals the complexity of responses to CSA, including feelings of shock (Hill, 2001; Hooper and Humphreys, 1998; Kilroy et al., 2014); anger and guilt (Hill, 2001; Kilroy et al., 2014); isolation (Hill, 2001); secondary trauma (Manion et al., 1996); and self-blame (Clevenger, 2015; Kilroy et al., 2014). Dyb et al. (2003) found parents of children abused outside the family still experiencing impacts of trauma four years after the events. Kilroy et al. (2014) summarised the collection of responses they found as "*systemic trauma".*

2.2.9 Child Sexual Abuse: Responses

Allnock et al. (2012), in a study investigating the need for therapeutic services for children affected by CSA, found evidence of:

> *"...a significant shortfall of treatment in services for children who have experienced abuse, even accounting for a very conservative estimate of numbers of children who would take up a service if it were available."* (Allnock et al., 2012:330)

Their findings are unlikely to surprise professionals or parents seeking to refer children and young people affected by sexual abuse for support. Whilst recognising that not all children require therapeutic support, Allnock et al. (2012) also note the evidence of successful outcomes for those who have been supported, with outcomes in interventions providing CBT having been extensively reported (Cohen et al., 2003, 2010; Cohen et al., 2004). Other types of CSA therapy, however, have been less systematically evaluated (Parker and Turner, 2014).

The rapid evidence report of the Children's Commissioner (Horvath et al., 2014) concludes that one difficulty in responding to CSA is that criminal justice and statutory systems rely on disclosure and evidence. Disclosure is problematic for children for a number of reasons, yet required by child protection systems in order to intervene. In an adversarial criminal justice system, courts need evidence to prove that abuse has happened, which means challenging children's allegations. Some interventions for children who have experienced CSA, including the one to which this study relates, require disclosure by children resulting in a joint or single investigation or strong belief in an allegation with accompanying protective action. Disclosure is acknowledged to represent a process rather than an event (Summit, 1983; Goodyear-Brown et al., 2012), one which is affected by family dynamics and context (Alaggia and Kirshenbaum, 2005). Children who are affected by CSA but have not disclosed may exhibit behavioural indicators as described in the section above on impacts, but the same behaviours may be seen in children without trauma experiences (Goodyear-

Brown et al., 2012). Thus children who have been sexually abused may have no response because their abuse is unknown, or they may receive a response to symptoms rather than specifically targeted at trauma associated with CSA.

The demand for evidence based interventions means that untested therapies are "*viewed with skepticism as other treatments are more thoroughly tested and found to be efficacious"* (Saunders, 2012:174). At the same time, the expanding knowledge base about CSA prompts the development of new therapies, discarding those that no longer appear to meet needs. Sexual abuse, Saunders says, is "*a historical event"* and "*best practice treatment does not target the event... it seeks to reduce abuse-related emotional and behavioural difficulties"* and prevent new difficulties from emerging (Saunders, 2012:176). As symptoms vary, interventions must represent the diversity of the group of children who have been sexually abused (Cohen et al., 2003; Finkelhor and Berliner, 1995; Goodyear-Brown et al., 2012). *DSM-5* includes sexual assault in the list of potentially traumatic events, although as Briere and Scott point out, "*the issue of whether an event has to satisfy current diagnostic definitions of trauma in order to be... 'traumatic' is an ongoing source of discussion"* (Briere and Scott, 2006:4). They argue that an experience is traumatic if it is "*extremely upsetting"* and "*at least temporarily overwhelms the individual's internal resources"* (Briere and Scott, 2006:4); therefore, children who are affected in this way by CSA may respond well to trauma-focused therapies. Effective interventions can reduce symptoms, but some symptoms are more resistant to treatment than others, notably conduct disorders and aggressive behaviours (Finkelhor and Berliner, 1995; Putnam, 2003), and some children get worse (Jones and Ramchandani, 1999).

Treatment outcome studies, supported by clinical experience, provide evidence of the influence of carer involvement in therapy for children (Corcoran and Pillai, 2008; Cohen and Mannarino 1998), and some interventions include the child's non-abusing parent in clinical interventions

(Cohen et al., 2004; Hill, 2005). As parental inclusion has become more common, the parent-therapist relationship has received more attention (Kazdin and Whitley, 2006) although the number of studies specifically addressing it is small (Karver et al., 2005). It is now recognised by many services that including significant family members in therapy for abused children is recommended because family participation helps children access treatment and can affect maternal support (Corcoran and Pillai, 2008). Services aimed at alleviating distress resulting from the abuse can help parents cope with negative feelings which impede their capacity to help children recover, and positive family changes may continue to protect and improve a child's outcome following intervention (Jones and Ramchandani, 1999). In some cases, assessment of a child's needs may conclude that the only intervention required may be undertaken by the non-abusing family member.

As research has added to knowledge about the breadth of experiences and impacts of sexual abuse on children, interest amongst professionals in providing "best practice" interventions for survivors has increased (James and Mennen, 2001). The call for evidence-based interventions and evaluated outcomes has resulted in a proliferation of studies aiming to provide empirical evidence about the effectiveness of a range of treatments. Nevertheless, systematic reviews of research into treatment effectiveness have found relatively few studies demonstrating sufficient rigour in methodology and design (Jones and Ramchandani, 1999; Macdonald et al., 2009; Macdonald et al., 2012; Ramchandani and Jones, 2003).

In the real world, treatment often does not go as planned. It is impossible to control what is happening outside the treatment context and therefore to know with certainty that measured treatment effects result from therapy, from other events occurring in a child's life, or from child individual characteristics that mean that his or her symptoms would diminish naturally. However, studies have demonstrated treatment effectiveness. Whilst it is widely accepted that the most "scientifically sound" research into treatment efficacy

involves randomised controlled studies under strict conditions (James and Mennen, 2001; Macdonald et al., 2012), it is also important to investigate therapeutic outcomes in natural settings (James and Mennen, 2001). In the CSA field, studies such as Berliner and Saunders (1996), Deblinger et al., (1996) and Cohen and Mannarino (1998) have addressed this need.

2.2.9.1 Child sexual abuse: intervention

Previous sections indicate that responses to CSA and CSE vary and that although a range of interventions have emerged for children affected by CSA, a gap exists between need and availability, and treatment effectiveness is not always evidenced. The intervention and the evaluation of which this study is a part were commissioned to bridge the service gap (Allnock et al., 2012) and address the need to demonstrate intervention effectiveness.

Recovery and Regeneration

The intervention used as a basis for its design Bannister's (2003) *Recovery and Regeneration* model, revised to fit the Agency's conceptual framework. Bannister's model was developed to meet the needs of all children affected by trauma, not only those who had been sexually abused, but its values and principles are consistent with the agency principles and aims and appropriate for work with children affected by CSA. Bannister assumes that traumatised children have embodied trauma memories which they are unable to formulate into cognitive stories and which remain unprocessed. The therapist's role is to help children 'process' their trauma, so that it no longer affects their development and frees them to move forward with their lives. The model emphasises the importance of assessment, recognises the skills required by therapists, and requires the development of a trusting relationship characterised by empathy and understanding. This special relationship, believed to promote change and healing, is commonly referred to as the "therapeutic relationship" or "alliance" and is essential for children to feel safe enough to explore and express negative feelings.

In adapting Bannister's model, the Agency devised a multi-theoretical approach which would meet the diverse needs of children and young people in a wide age-range, with different experiences, along with their parents and carers. The intervention guidance proposes that practitioners be skilled in using various therapeutic approaches within the framework. *Recovery and Regeneration* is psychodynamic in nature and influenced by trauma theory and play therapy, and two related therapeutic approaches are described briefly below. In addition, the agency recognised the value and evidenced effectiveness of cognitive behavioural therapies for some sexually abused children and their parents, and this approach is also presented here.

Cognitive behavioural therapy

Cognitive behavioural therapy (CBT) represents a broad range of therapies based on learning theory and focusing on links between thoughts and behaviour. Some therapies involve safe carers and include educational components (Allen and Johnson, 2012; Pollio et al., 2011; Saunders, 2012). CBT is used to treat a variety of disorders and trauma effects among children and adolescents (Wethington et al., 2008). There exist a number of studies related to CBT for sexually abused children (Cohen et al., 2004; Cohen and Mannarino, 1996; Cohen and Mannarino, 1998; Deblinger et al., 1996; King et al., 2000). Generally, strongest evidence for positive effects of CBT has been in reducing PTSD symptoms and anxiety, but even these effects have been described as "moderate" (Macdonald et al., 2012:2) and "*less robust than had been assumed*" (Coren et al., 2009:30).

Integrative Treatment for Complex Trauma for Children

Other therapies focusing on trauma have been developed for children. Whilst these models are widely used, they have not been as rigorously tested as CBT interventions. The *Integrative Treatment for Complex Trauma for Children* (*ITCT-C)* (Lanktree and Briere, 2008) addresses children's trauma issues in an openly integrative and holistic way, drawing from different theoretical and clinical perspectives. It is described by its authors as:

> *"...a comprehensive, assessment-driven components-based model, integrating theoretical and clinical approaches for the treatment of complex trauma in children and adolescents."* (Lanktree and Briere, 2008:4)

The model's theoretical base is wide: it draws on cognitive behavioural (learning) approach, complex trauma theory, and attachment theory and focuses on affect regulation, trauma processing and identity development (Lanktree and Briere, 2008:17).

Trauma-focused Integrative Play Therapy

A different trauma-focused intervention is *Trauma-Focused Integrated Play Therapy (TF-IPT)* influenced by the work of Judith Herman (1992, cited in Gil, 2012:251). Play therapy aims to use symbolic communication to reduce stress and anxiety, and *"allows the child to process … trauma in a manner that can be consciously understood and tolerated*" (Pollio et al., 2011:270). Gil's model is a phased integrated model, borrowing from CBT and expressive therapy practices such as play, art, and drama. These techniques are believed to be particularly suited to children because they do not rely on verbal communication. Trauma-focused play therapy is widely used with children who have experienced sexual abuse, but is supported by little empirical evidence (Saunders et al., 2003).

2.2.10 Summary

Part 1 has provided an overview of the issues related to defining CSA and referenced literature on prevalence, impacts, and interventions for children. It has presented a summary of the model upon with the *Agency's* intervention is based, emphasising the significance of the therapeutic relationship. Part 2 discusses the relevant concepts and literature related to the therapeutic relationship, and its association with positive outcomes of therapy.

2.3 Part 2: The therapeutic relationship

2.3.1 Introduction

The term ‘therapeutic relationship’ used throughout this thesis is derived from the term ‘therapeutic alliance’, or ‘working alliance’, which originated in psychoanalytic theory (Bordin, 1979). The phrase ‘therapeutic relationship’ distinguishes this study’s emphasis, methodology, and social constructionist framework from much of the established research on ‘therapeutic alliance’. ‘Therapeutic relationship’ is also favoured as more accessible to participants, is the phrase used in the intervention guidance, and is familiar as a general term used by practitioners who work with children and young people. This part of the literature review provides an overview of the concept of the therapeutic relationship including the notion of therapeutic or working alliance, introduces the views of the relationship in different therapeutic orientations, and describes briefly the development of instruments to measure therapeutic alliance for adults and children. It refers to research supporting the association between the quality of relationships in therapy and treatment outcomes, and locates the therapeutic relationship in the current literature and thinking about interventions with children and young people. In presenting the literature, the thesis uses the language of the papers to which it refers.

2.3.2 What is “therapeutic relationship”?

> *“Attempting to describe the almost imperceptible but fully present subtle nuances characteristic of a shared relationship with the person of a child is a bit like trying to pick up a small bubble of mercury with your fingers.”* (Landreth, 2002:79)

Landreth’s words highlight the difficulty in defining the terms ‘therapeutic relationship’ and ‘therapeutic alliance’. Gaston (1990), in tracing the theoretical history of the concept’s development, refers to the “*mosaic of the different theoretical viewpoints”* (Gaston, 1990:145). The two terms are often used interchangeably in the literature (Chu et al., 2004), although some argue that strictly they are not the same and the “alliance” is but one aspect

of a relationship having many constituent parts in therapy. 'Therapeutic alliance' has been much debated (Horvath, 2006; Horvath and Greenberg, 1989; Safran and Muran, 2006), but is understood to describe the collaborative relationship between a therapist and a person receiving therapy. It is a dynamic phenomenon, a process which alters during in the course of therapy (Zack et al., 2007). Horvath (2001:365) defines alliance generically as referring "*to the quality and strength of the collaborative relationship between client and therapist in therapy*." This relationship includes "*positive affective bonds*" and cognitive aspects related to collaboration on therapeutic goals and the means of achieving them (Horvath, 2001:365). The conceptual distinctions between the 'alliance' and other aspects of the therapeutic relationship are not easily seen. Horvath (2006) cites Norcross (2002) as listing "*11 elements and eight processes within the framework of therapeutic relationships"* including, for example, "*alliance", "empathy", "positive regard", "congruence"* and "*relational interpretation"* (Horvath, 2006:260). Horvath suggests that these elements overlap, and challenges the logic and usefulness of subdividing the concept of the therapeutic relationship into so many parts (Horvath, 2006:260). He points out that not only do the number of elements make developing consensus on a "*conceptual map"* of the relationship difficult, but the different tools created to measure in practice a phenomenon which is not yet consolidated conceptually defy efforts to ensure that each researcher is measuring the same thing (Horvath, 2006). It is difficult to see from the vantage point of those receiving therapy that the number or name of constituent parts of their relationship with their therapist is helpful to them. It is, however, useful for practitioners to know what it is that they do that is helpful to clients, and Horvath suggests that attention to *"processes"* and "'*small o' outcomes"* (Horvath, 2006:261) might provide a way to gain this knowledge.

Much research concurs in principle with the concept of therapeutic alliance as collaborative and having affective and cognitive elements. The language

used to describe the construct differs however, and methods for measuring alliance are variable (Cahill et al., 2008; Elvins and Green, 2008; Meissner, 2006). Definitions and measurements related to the therapeutic alliance and therapeutic processes in work with children and young people lag behind adult literature (DiGiuseppe et al., 1996; Karver et al., 2006; Kazdin and Nock, 2003; Shirk and Karver, 2003; Shirk and Saiz, 1992; Walter and Petr, 2006; Zack et al., 2007).

2.3.3 Perspectives on therapist-client relationships

2.3.3.1 Therapeutic Alliance - Conceptual Development

The proliferation in number and variety of therapeutic methods and services was accompanied by a mission driven largely by clinicians and researchers in fields of psychology and psychoanalysis to evaluate empirically the processes contributing to therapeutic change. Clearer conceptual definitions of the therapeutic alliance led to the development of operational definitions and subsequently to a number of measurement tools (Elvins and Green, 2008; Horvath, 2011a; Zack et al, 2007). One of most notable contributors to conceptual clarity was Bordin (1979) who proposed three principal components of a therapeutic relationship: the creation of a bond between therapist and patient, the agreement on therapeutic goals, and collaboration on tasks to achieve the goals. He envisaged the working alliance as key to the change process regardless of treatment context (Bordin, 1979; Horvath and Luborsky, 1993). Bordin describes the strength of a working alliance as:

> *"...a function of the closeness of fit between the demands of a particular kind of working alliance and personal characteristics of patient and therapist."* (Bordin, 1979:253)

Bordin's "*pan-theoretical*" definition (Horvath and Luborsky, 1993:563) suggests it is possible to explore the quality of the relationship between worker and service user in different therapy settings. Luborsky (1976, cited in Horvath 2006) similarly defines the therapeutic alliance as incorporating the co-existence of affective and collaborative elements. Luborsky and

Bordin emphasise the "*conscious and reality-based aspects*" of the therapeutic alliance (Horvath, 2006) in contrast to the focus on the unconscious mind and transference characterising relationships in psychoanalysis.

The therapeutic relationship is associated with psychotherapeutic treatments and dates back to Freudian psychoanalytic tradition and the concept of transference. Freud observed that patients would unconsciously link the therapists with "*images of people by whom he was accustomed to be treated by affection"* (Freud, 1913:139-140, cited in Horvath and Luborsky, 1993:561). Horvath and Luborsky (1993) note that Freud later recognised that this relationship might be conceived as real for the patient, and might help enhance the therapeutic process. Bordin (1979) identifies two "*foundations*" of the working alliance in psychoanalytic literature: the notion of the "*therapeutic contract*" or alliance between therapist and the client's "*rational ego*", and idea of the "*real*" relationship (Bordin, 1979:253). In psychoanalytic terms, there is a distinction between the real relationship, existing in the client's cognitive and present world, and the fantasy relationship of the unconscious mind. It is the fusion of these notions that Bordin (1979) says lie behind his concept of the working alliance.

The therapeutic relationship concept developed further through the influence of Anna Freud who described an alliance providing opportunities for recovery and change (Freud, 1946, cited in Shirk and Saiz, 1992:715). Lanyado and Horne (2009:157) state that the therapeutic relationship "*lies at the heart of all psychoanalytic work and is the main vehicle for psychic change."* In child therapy, they view the therapist role as providing an empathic, non-judgmental, warm relationship experience within which children can grow and change. Essentially, the relationship is seen as a key to the intervention.

Therapeutic relationship as derived from the psychoanalytic concept of transference is but one way of understanding the relationship between therapist and client. Herman (1992) describes the original definition of

transference as potentially unhelpful and re-traumatising for adults affected by relational trauma such as CSA, and views attachment-based and humanist approaches as more appropriate for abuse survivors. Attachment and trauma perspectives provide an alternative understanding of the therapist-client relationship, accepting the influence on people in therapy of previous relational experiences but seeing these in the context of real trauma and loss rather than in solely unconscious processes. Attachment and trauma theories propose that children's traumatic experiences destroy their core belief in parents' protective capacity, but that the quality of attachments aid recovery as well as relationship development in therapy (Busch and Lieberman, 2007). The provision of a secure base, as Bowlby instructs (Bowlby, 1988) is the first requirement for therapists applying attachment theory in their work.

Humanists also see the relationship as more "real" and grounded in the "therapist-client encounter" (Horvath, 2006). It is the way clients experience the therapeutic relationship – the empathy and acceptance provided by the therapist – that matters, and enables clients to develop the capacity to change (Rogers, 1951). Many humanist therapies are flexible, creative and attuned to the unique needs of individual clients (Sanderson, 2006). Rogers believes in genuineness, acceptance and a desire to understand how another person feels, and recognises the significance of empirical research on therapeutic experiences of clients and the measurement of successful outcomes (Rogers, 1951).

Rogers' approach had a significant influence on play therapists, like Gil (2006), who, whilst borrowing techniques and features from cognitive behavioural interventions, argues that rigid cognitive behavioural programmes do not suit many traumatised children and recommends the development of more integrative therapeutic interventions around the needs and characteristics of the child (Gil, 2006). The ethos of the therapeutic relationship is embodied in the principles of play therapy with children: "*Therapy is conducted in the context of a therapeutic relationship which*

allows the expression of the child's feelings" (Wilson and Ryan, 2008:17). Different therapists emphasise particular facets such as empathy (Crenshaw and Hardy, 2007) or safety (Bowlby, 1988) in the relationship, but play therapy in general adheres to principles outlined by Axline (1969). Play therapy is closely related to Rogers' person-centred approach (Wilson and Ryan, 2008), and accepts that therapy with children requires a developmental approach and skills and understanding appropriate for communicating with children. Much play therapy is described as 'non-directive', a term which has been misunderstood as indicating that the therapist contributes nothing to the process; Wilson and Ryan (2008) clarify that the non-directive approach incorporates a reflexive listening stance and encourages children to decide which issues they want to work on in sessions.

2.3.3.2 The "therapeutic space"

In clinical literature, therapeutic relationships are sometimes connected with the concept of a "therapeutic space". The idea of relational space – encompassing physical, social and affective dimensions – provides a useful conceptual structure for the therapeutic relationship and all that occurs in this context. The phrase "therapeutic space" has no single definition, but is used variously to reference the qualities of the therapeutic relationship, the context, the process, or all three. Flaskas (2005) talks about "*the space between"* as a "*space within the therapeutic relationship between therapist and family, where mutual influence and change is possible"* (Flaskas, 2005: xxi). The phrase is described by Bronstein and Flanders (1998:10) in their development of a therapeutic space for adolescents requesting help for the first time as: "*the possibility of enabling the development of a space for thinking"* (Bronstein and Flanders, 1998:11). It is therefore a space of potential. For Alayarian (2014) it is a "*safe space"* (Alayarian, 2014: Kindle edition, Ch 2 Section 4, loc 878) where being in the presence of someone

listening and understanding can make a life-changing difference. Bassett et al., (2014) draw on metaphor to describe the process of therapy, starting with the concept of a therapeutic space:

> *"We enter a new space (therapy) and meet a helper (the therapist), we go into the forest (the therapeutic journey) and encounter adversaries and challenges (internalized oppressors both real and imagined."* (Bassett et al., 2014: Kindle edition Chap 10, Section 6 Loc 3274**)**

Finally, Donovan (2002) argues for appreciation of a "*generic therapeutic space"* in an age of proliferating therapeutic specialisms – suggesting that the important therapeutic role of social workers is often underplayed. Her use of the word "space" is different from Bronstein's, but it offers the idea that the "therapeutic space", the space where potential for change occurs, need not be restricted by traditional paradigms and definitions of therapeutic schools of practice.

2.3.3.3 Social constructionist perspectives

Psychoanalytic approaches focus on the individual mind, specifically the 'state of mind' of the person seeking therapy (Gergen, 2015). Meaning which is perceived to originate solely in the individual mind is a premise which troubles constructionist thinkers who believe, as Gergen states, that:

> *"...it is not the individual who pre-exists the relationship and initiates the process of signification, but patterns of relationship and their embedded meaning that pre-exist the individual."* (Gergen, 2003:148)

Constructionist therapy, unlike much traditional psychotherapy, focuses on the co-construction of meaning within relationships (Gergen, 2015:176). The therapeutic relationship represents but one amongst many relationships in which therapist and individual help-seeker are engaged, and the focus of the therapy becomes "*an exploration of the networks of relations in which the individual participates"* (Gergen, 2015:176). It is nothing if not collaborative. This focus does not deny the idea of a particular kind of connection (a bond), joint participation in dialogue and agreed activities (tasks), or agreement

about the aims and desired changes in a person's life (goals), although it is the individual's perception of change that matters, not the therapist's. Nor does it deny that individuals have internal conversations with others present/not present or real/unreal. The notion of relationship in constructionist therapy confirms and challenges common notions of "therapeutic relationship" as the medium of change, because it sees the responsibility of the therapist in a different light. The therapist may work with theories in mind, but "*these constructions lose their privilege over all others"* and the therapist must question their usefulness in each case (Gergen, 2015:176). The therapist is not responsible for change, but can create a collaborative, relational space in which change can occur, or in constructionist terms, where co-construction of alternative realities is possible. Fruggeri (1992) talks of the "*ethical"* responsibility of the constructionist therapist to understand "*psychotherapy as a context of constructing social realities"* (Fruggeri, 1992:47). The only realities that matter are the ones which are understood and meaningful to the client, a view which varies from traditional idea of the therapist as expert. The therapist, Fruggeri suggests, "…*should take responsibility for his or her power of construction within the constraints of the relational/social domain"* (Fruggeri, 1992:47). Power, respect, and egalitarianism in constructive therapy are mutually and interactively determined (Fruggeri, 1992). Power is complex and can be hidden under the guise of equality and cooperation, which in social work terms would make anti-oppressive practice an illusion – particularly damaging for children and young people who have already been manipulated and betrayed by CSA. Similar principles exist in social work literature and guidance on partnership working where communication skills, attention to power dynamics, and reflexivity are emphasised in direct therapeutic work with children (Ryan et al., 1995) and in use of constructive social work methods (Parton and O'Byrne, 2000). Fruggeri sees progress in the relationship as ensuing from questions or challenges which invite clients to see their lives differently:

"It seems that, in a therapeutic relationship, the challenge to the coherence between description and beliefs constitutes a perturbation which challenges the individuals to generate a new coherence." (Fruggeri, 1992:50)

2.3.4 Measuring Therapeutic Alliance

Review of the literature reveals a number of instruments which sprang from alliance constructs, initially developed for use in individual adult psychotherapy (Horvath et al., 2011a; Elvins and Green, 2008; Shirk and Karver, 2003; Cahill et al., 2008), and eventually moving into couple and family therapy (Friedlander et al., 2006). Horvath et al. (2011a) identified, amongst the 36 scales included in their meta-analysis, "core measures" derived from the concepts of Bordin (1979) and Luborsky (1984, cited in Elvins and Green, 2008). These included the *Working Alliance Inventory (*WAI)(Horvath and Greenberg, 1989), *California Psychotherapy Alliance Scale* (CALPAS)(Gaston and Marmar, 1994), and *Helping Alliance Questionnaire* (HAq)(Alexander and Luborsky, 1987).

Initial measurements of child and youth alliance involved adaptations of adult instruments (Diamond et al., 1999; DiGiuseppe et al., 1996), but by the 1990's instruments were being developed specifically for use with children and young people (Faw et al., 2005; McLeod and Weisz, 2005; Shirk and Saiz, 1992). The *Therapeutic Alliance Scale for Children (TASC)* (Shirk and Saiz, 1992) was the first scale to be designed for and tested with younger children.

2.3.4.1 Therapeutic Alliance Scale for Children

Research supports the premise that the therapeutic relationship is measurable using observational methods and questionnaires, or scales (Ardito and Rabellino, 2011; Barber et al., 1998; Beck et al., 2006; Faw et al, 2005; Green, 2006; Horvath and Greenberg, 1989; Horvath et al., 2011a; Shirk et al., 2011; Zack et al., 2007). The *TASC,* designed to evaluate

children's experience of therapeutic relationships, were first used to study the strength and quality of relationships in inpatient treatment for children. Researchers have used the scales to examine relationships in community based mental health services (Hawley and Weisz, 2005), in manualized cognitive behavioural therapy programmes for treatment of anxiety (Creed and Kendall, 2005), and amongst children being treated for severe emotional or behavioural difficulties (DeVet et al., 2003). In creating the *TASC,* Shirk and Saiz (1992) examined the research on adult therapeutic alliance and the emerging findings on youth and child alliance, and determined the need for scales which were developmentally sensitive to children's needs, notably children in clinical environments. They noted that children's experiences of the therapeutic process had been "*largely ignored by clinical researchers*" (Shirk and Saiz, 1992:714). Additionally, in practice, self-reporting by children and adolescents about symptoms and experiences tended to be given less credence than for adults, and where children and adolescents were referred for treatment by adults the adult view of problematic symptoms often predominated (Kendall and Morris, 1991). Given the theoretical perspectives emphasising the importance of the relationship in children's therapy which underpin psychoanalytic and psychotherapeutic practice, and noting the increasing interest in the therapeutic relationship amongst behaviour therapists, Shirk and Saiz (1992) proposed that research focusing on the relational context was overdue.

2.3.5 Importance of Therapeutic Alliance in Treatments – Research Findings

Research has found consistent and "modest" association of therapeutic alliance with outcomes in treatment studies (Elvins and Green, 2008: 1168). The alliance-outcome effect has been noted across different types of interventions and in all service user populations (Karver et al., 2006; Martin et al., 2000; Shirk and Karver, 2003; Shirk and Karver, 2011). Many studies have focussed on a variety of different tasks, therapist skills and patient-

therapist characteristics to try to establish their significance in building and maintaining a therapeutic alliance in adult studies (Ackerman and Hilsenroth, 2003; Brent and Kolko, 1998), and child and youth studies (Creed and Kendall, 2005; Hawley and Weisz, 2005). Treatment programmes and practices which ignore the importance of the therapeutic relationship are believed to be less complete (Norcross and Wampold, 2011).

Empirical research related to youth therapeutic alliance has been described as lacking and deficient (Zack et al., 2007). The complexities of child and family engagement with therapeutic processes and the need to consider therapist relationships with parents as well as with children make the task of establishing exactly what is significant, when, and for whom, difficult (Walter and Petr 2006). Although the evidence supports the alliance-outcome association in interventions with children, it remains hampered by the lack of a clear definition, which in turn is associated with the plethora of measurements and study designs (Shirk and Karver, 2003). It is not possible to make definitive causal statements about the direction of therapeutic alliance-outcome effects (Barber et al., 2000; Hawley and Weisz, 2005; Kazdin and Nock, 2003). Children's therapeutic interventions may also involve carers or parents, but few studies have examined the relationship between caregivers and therapists (Accurso et al., 2013). Exceptions are Diamond et al. (2000), Kazdin et al. (2006), Hawley and Weisz (2005), and Jensen et al. (2010) whose research was qualitative.

2.3.6 Challenges of developing and measuring alliance in youth therapy

> *"I'd rather eat glass than sit here and talk to you."* (McGee and Holmes, 2012:447)

Engaging children and young people in therapeutic working alliances can be challenging (Shirk et al., 2011). It is therefore surprising that in an area where there has been concerted focus on determining what types of interventions are most effective, less attention has been paid to relationships in therapy with children and young people than with adults (DiGuiseppe et al., 1996; Green, 2006; Zack et al., 2007). One of the difficulties, as Chu et

al. (2004) explain, is that despite its recognised importance *"child alliance research has yet to develop a unifying definition and methodology for assessment"* (Chu et al, 2004:45). In their discussion of the construct of youth alliance, Zack et al. (2007) say:

> *"Given that interpersonal relationships are developmentally important across the life span, and given especially that the therapeutic relationship plays such a central role in psychotherapy, the relationship between youth and their therapists seems to be an especially fruitful target for further clinical research."* (Zack et al., 2007:279)

Adolescents and children are likely to be referred to therapy by others and may have different ideas about their goals, and many scales for youth alliance set out to measure only constructs related to development of a bond and agreement on tasks (Chu et al., 2004:45). There is, on the one hand, evidence that adolescents are well aware of their problems and desire change, in which case therapist-adolescent consensus on goals may be crucial to continued attendance (Zack et al., 2007; DiGuiseppe et al., 1996). However, Faw et al. (2005) suggest that perhaps for young people, it is the bond element of the therapeutic relationship which is most important, and children interviewed have reported positive feelings about their therapists (Carroll, 2002). Whilst adults may be able to understand their problems and discuss how to resolve them, children's differential cognitive and emotional processing is likely to mediate their ability to engage in this way, a proposition supported by Jensen et al. (2010) who found that children were less likely to appreciate the overall goals of therapy, and that caregivers and therapists "*collaborated*" on the development of a bond between child and therapist. This finding is consistent with Hawley and Weisz (2005) who found differential roles of child-therapist and parent-therapist alliances in the therapeutic process. DeVet et al. (2003) unusually investigated the affective element of the therapeutic relationship from the perspectives of both mothers and their children with the children's therapists. They used the *Therapy Bond Scale* from the TASC (Shirk and Saiz, 1992), modifying it for mothers, and found that, as they predicted, children's relationships with their

mothers were positively related to their rated perceptions of bond with their therapists (DeVet et al., 2003).

Much of the clinical research with children and youth seeks to describe the quality and strength of the therapeutic relationship using instruments which operationalise concepts related to affective and cognitive components of the relationship (Accurso et al., 2013; Bickman, 2004; Diamond et al., 1999; Roest et al., 2014), and various methods to determine the association of the relationship with therapeutic outcomes (Chiu et al., 2009; Eltz et al., 1995; Garcia and Weisz, 2002; Kendall, 1994; Kendall et al., 1997; McLeod, 2011; Robbins et al, 2006; Shirk and Karver, 2003; Shirk et al, 2011). Such studies contribute significantly to the understanding of the role of the therapeutic relationship in helping children and young people through therapy. However, many of them lack the richness, variety of views and valuable insights which qualitative perspectives of the children, parents and therapists can provide. Such data is available in the smaller but important qualitative studies on children's, parents', and practitioners' views of the relationships developed in therapy.

2.3.7 The contribution of qualitative research

Qualitative research, such as Jensen's et al. (2010) investigating participant views of the therapeutic relationship with children, is relatively rare. Studies which record children's perceptions on their experiences of abuse and healing mention positive experiences with helping professionals (Foster and Hagedorn, 2014) or views on what helped in therapy (Nelson-Gardell, 2001) but do not focus on therapeutic relationships. Both Possick et al. (2015) and Campbell and Simmonds (2011) explored therapist perspectives on the therapeutic process, but only the latter study was specifically concerned with the therapeutic alliance. Campbell and Simmonds (2011) used mixed methods to examine perspectives on alliances with children/adolescents. As their study also addressed issues related to therapist relationships with parents, it bears similarities to the study which is the subject of this thesis. There is also strong symmetry in methods and ethical approach with

Carroll's (2002) study in which she interviewed therapists and children about their experiences of play therapy. Carroll (2002) found the importance of the therapeutic relationship stood out in interviews and the children to be *"deeply engaged"* in the relationship (Carroll, 2002:181). Children identified specific therapist behaviours which helped, including being offered choice in sessions, the assurance of confidentiality, and the importance of personal qualities such as kindness and friendliness (Carroll, 2002). Eyrich-Garg (2008) also found that confidentiality was important to a group of adolescent girls in building a therapeutic relationship, along with specific therapist behaviours like paying attention. Such details both provide feedback to children that their views are important and were heard, and also inform practitioners and policy makers. Listening to the views of people involved in the therapeutic process leads to better understanding of their experiences, an expanded knowledge base, and a more informed approach to practice.

2.3.8 Summary of literature reviewed

The research findings discussed above provide a theoretical and empirical background for the research questions. There is substantial evidence that CSA is a significant problem in the UK, has harmful immediate and long-term consequences for some children, and that some children and young people require interventions. It is accepted by clinicians and researchers that interventions for abused children should be evidence based and rigorously evaluated to ensure that they are effective and represent "best practice", and studies examining the outcomes of interventions have increased over the past twenty years. Rigorous evaluation of creative therapeutic interventions lag behind studies of cognitive behavioural treatments, and evaluation studies relating to programmes specifically for children affected by CSA are rare. Further, qualitative studies of the therapeutic processes underpinning children's experiences and progress in interventions are uncommon.

It is widely recognised that one of the important processes associated with outcome is the "therapeutic alliance" consisting of both affective and collaborative components. There have been many contributions to the

development of a concept and definition for the alliance, with one of the most important being Bordin's (1979). Empirical support for Bordin's model has grown in the field of adult therapies, but is less established and less certain in interventions for children and young people, and more research is necessary.

Further qualitative study of the nature and characteristics of therapeutic relationships in children's therapy will support and add to the growing evidence base. There are few studies with sexually abused children providing an in depth focus on the relationships between therapists and children, and therapists and safe carers. Studies which use multiple sources and different methods to explore therapeutic relationships can help provide a more complete understanding of the therapeutic process.

The next two chapters describe the study's framework and methodology. Chapter 3 presents the personal influences and theoretical framework underpinning the research approach and process. Chapter 4 describes the methods used to answer the research questions, and discusses issues related to interviewing in sensitive research with vulnerable groups, ethical considerations, and the analytical process.

3 Chapter 3: Methodological approach and theoretical framework

3.1 Chapter overview

This Chapter presents the methodological approach to the '*Me and My Worker*' (MMW) study, and describes the personal and theoretical influences on decision-making in the research process. Two strands contribute to the framework for this study: social constructionism and its methodological links with interpretivism, and my social work practice experience with families affected by hardship, abuse and trauma. These experiences are informed by the social work knowledge base relevant to the nature and power of relationships in facilitating change. The chapter begins with a brief reflective analysis of how practice informs my research approach. I began this project with an appreciation of the importance of relationships in work with children and adults affected by abuse, and an understanding that my background and values would affect the research relationship with different groups of participants. Such transparency is methodologically consistent with research adopting a social constructionist perspective with underlying principles of openness, reflexivity, attention to language and context, and acknowledgement of power in the research relationship (Hesse-Biber and Leckenby, 2004).

This research examines the nature and quality of relationships developed from the perspectives of the children, safe carers and practitioners through the lens of social constructionism, introduced in the second section. This approach prioritises the voices of participants, emphasizes reflexivity, occurs in the context of a researcher-participant relationship, and accepts the restrictions of language. There is a fascinating symmetry in creating the opportunity to explore the perspectives of therapeutic relationship predicated on connection and communication and viewed as a constructive process (Gergen, 2009; McNamee and Gergen, 1992) through a research relationship also predicated on connection and dialogue. The section presents social constructionism as a fitting framework for the research,

includes a brief discussion of the origin of social constructionism, draws attention to critiques of its position, and introduces the principal social constructionist writers informing the thesis.

The third section expands on Chapter 1 making the case for the use of mixed methods in this study. The final section in the chapter discusses the place of reflexivity in a social constructionist framework.

3.2 The influence of social work practice on research

Working environments and wider context have significant impact on social work practice. Policies, working conditions, management roles, lines of accountability, legislative frameworks, and contemporary political, social and cultural contexts affect social workers on a daily basis. My practice experience spanned the years when awareness and knowledge about CSA were expanding.

Social work with children involves working in partnership with individuals, families and other agencies, understanding the dynamics of abuse and neglect, and assessing risk and resilience in families and young people. In the politically charged, challenging and sensitive arena of safeguarding, communicating, building relationships and engaging in complex social interactions are crucial aspects of the work. In busy social care teams, process and structure impinge on the professional helping relationship, and developing good working relationships with service users at times seems frustratingly out of reach. The pressures of the working environment and the growth of what Munro (2011) identified as ripple and feedback effects of over-prescriptive practice, including increased bureaucratization and electronic recording demands, have unintended consequences of eroding relational aspects of the work. The consequences of such erosion make social workers feel deskilled, colour the relationships formed with service users and affect the quality of service and outcomes for children and families.

Blewett et al. (2007:6) identified seven core components of social work tasks, of which three have particular resonance in framing this research and are discussed below:

a) Understanding the dynamic between the individual and the social
b) The transformatory significance of the relationship
c) The therapeutic role of social work

3.2.1 The individual-social dynamic

The individual-social dynamic is relevant to consideration of relationship-based work, the social constructionist perspective, and research investigating the quality and nature of relationships developed in therapeutic practice. All individuals inhabit social systems. We are interconnected, our relationships evolve and transform, and "*our very experience of self is shaped by our relationships with others, just as they are shaped by their relationship with us*" (Howe, 2009:158). This premise underlies familiar social work theories such as ecological principles (Bronfenbrenner, 1977; 1995) and systems theory (Franklin et al., 2013; Payne, 2014; Pincus and Minahan, 1973) which connect people to their local and wider networks. It also pertains to constructive social work (Parton and O'Byrne, 2000) in its solution focus and recognition of the influences of culture, oppression, power, and social institutions on individuals in society. The ecological approach, which embeds individuals in their social and physical environment, underpins the Assessment Framework for Children in Need and their Families (AF) (DoH, 2000). As a practice model it embraces principles of relationship-based work. Social workers need to form working relationships in order to undertake complex assessments, and the AF emphasises children's interconnected relational worlds, and the social, economic and political structures in which these exist (Jack, 2001; Jack and Gill, 2010, 2010a). The AF is also compatible with systems theory which stresses the complex web of interconnections in people's everyday lives, and assures, in principle, that assessments and interventions are contextualised within their social worlds. There were times, however, where

my experience was of organisational demands which seemed to obstruct rather than facilitate the development of effective working relationships, with service users and other agencies.

3.2.2 The transformatory significance of relationships

The purpose of social work relationships with children and families generally is to promote change, and the idea of relationships as transformatory is central to the design of the intervention linked to this study. Understanding of the power of relationships helps practitioners appreciate how people experience their place in the social world, their behaviour and feelings in relation to others, and the variable responses to services. In work with families where trauma related to abuse provides the rationale for intervention, the ability to connect with people is a key skill. Various theoretical approaches support the importance of relationships in working towards change, including psychodynamic (Sudbury, 2002), psychosocial (Megele, 2015), attachment (Howe, 2005), person-centred (Rogers, 1951; 1961) and constructionist. There is in both social work and therapeutic practice evidence that success of an intervention is related to more than just the model or technique used and that the "*quality and value of the experience*" (Parton and O'Byrne, 2000:11) are important. As Howe says, "...*the way people treat us matters*" (Howe, 2009: 155).

3.2.3 The therapeutic role of social work

Linked with the capacity of relationships to promote change is the understanding of social work as therapeutic – both in the formal sense of providing therapeutic services, and in the informal sense of the relationship being experienced as restorative, healing, or helpful. The emphasis on relationship-based social work in the UK diminished in the last two decades of the twentieth century as the care management systems, commissioning, and different methods of intervention became popular (Blewett et al, 2007). However, the importance of relating to people who use services has not disappeared, and the social work profession in the western world resists

identification solely as an agent of control, holding on to values of care, compassion, engagement, and partnership.

Much social work practice is about interaction and communication, helping individuals to see the world differently and to reframe and reconstruct their experiences (Parton, 2009a). In assessment and planning with families who have experienced hardship and trauma the quality of the relationship can influence the course of the work. Assessment can be viewed as therapeutic if it is person-centred, anti-oppressive, compassionate, solution-focused, and understands individuals in relationships with others (Dominelli, 2009; Bannister, 2001).

Rogers' (1951) understanding that how we relate to people can be as important as what we say has influenced social work practice, and social workers are responsible for an array of interactions including therapeutic interventions (Howe, 2009; Trevithick, 2012; Jones et al., 2008). Relationships continue to form part of the social work practice landscape:

> *"Relationships are crucial in social work. In social work ... the quality of the relationship and ensuing communication virtually determines the nature of the work."* (Jones et al., 2008:89)

3.3 Social constructionism and the study of therapeutic relationships

> *"… the moment we begin to speak together, we have the potential to create new ways of being."* (Gergen, 2009:28)

The approach to this study is influenced by the description of therapy as social construction, particularly as presented by Gergen (2003, 2006, 2009, 2015). Social constructionists tend to see meaning as originating in relationships (Gergen, 2009) and language as both limiting and liberating: limiting because every argument possesses what Gergen characterises as a "*profound fragility*" by virtue of the ambiguity of its terms (Gergen, 2009:21) and liberating because speaking together opens doors to new possibilities.

For people who have experienced trouble in their lives, the "*potential for creative reconstruction is a continuous treasure*" (Gergen, 1998:415).

This study examines relationships developed in the particular context of a therapeutic intervention. The research questions seek to investigate, from the perspectives of those involved, the nature and quality of relationships, how each person experiences them and perceives changes occurring within them. A fitting framework for these questions is social constructionism which acknowledges that individuals' everyday social realities are varied and relational, encourages reflexivity, and focuses more on processes than on structures (Burr, 2015).

3.3.1 Social constructionism: origins

Social constructionism is a philosophical position accepting an idealist, or relativist stance (Patton, 2002:97) and holding that there is no one reality or truth: there are many realities constructed by social actors (Blaikie, 2007). Berger and Luckmann (1967) describe the social world as limited by the natural world, but at the same time interacting with it:

> *"In the dialectic between nature and the socially constructed world the human organism itself is transformed. In this same dialectic man produces reality and thereby produces himself."* (Berger and Luckmann, 1966; 1991 Kindle Edition: 204)

It is through interactions, or what Gergen and Gergen (2003:2) describe as "*communal interchange*", that social actors construct their realities. These realities are multiple, ever evolving, and experienced as both subjective and objective, meaning that different groups and different individuals may experience the same event in different ways.

Social constructionism is anti-essentialist, supports the idea that knowledge is historically and culturally specific, and views language as both a "*pre-condition for thought*" and a "*form of social action*" (Burr, 2015:10). As interchange involves communication with others, the role of language and discourse is central to understanding, and the influence of Wittgenstein's (1978) "*language games*" is apparent (Burr, 2015; Gergen and Gergen,

2003). Berger and Luckman (1967) see language as the medium of understanding about the everyday world, including human relationships, writing that through language, *"…an entire world can be actualized at any moment*" (Berger and Luckmann, 1967:54).

Two assumptions which Gergen (2009) claims are integral to social constructionist research are, firstly, that the world and peoples' experience in it are understood in terms of constructions, and secondly, that knowledge of the world is not derived inductively but constructed in multiple historical, cultural and gendered contexts (Blaikie, 2007). The concepts and institutions with which we are concerned – childhood, family, marriage, parenthood, child abuse – are constructions, products of relationships and communication, and are dynamic, varying across time and culture. The changes that we can describe over time do not reflect changes in the *"objects or entities of concern but seem lodged in historically contingent factors*" (Gergen, 2003:15).

3.3.2 Critiques of social constructionism

Social constructionism provokes understandable criticism and concern and raises dilemmas within the constructionist position itself. Whilst there is not scope in this thesis to discuss critiques in detail, it is important to note them. Two criticisms relate to the undermining of the existence of universal truth and reality, and the consequential threat to moral decision making. The arguments that, for example, death is an undeniable reality for all humans and that murder is wrong pose problems even within the social constructionist movement. Death, in the sense of the physical body ceasing to function is not an illusion. More complex and value-laden is the question of death by murder, which raises issues about when societies permit the killing of people; when killing equals murder; whether there is an absolute right or wrong; and who has the right to make the decision. Burr (2015) suggests that if the social constructionist's aim is:

> *"...to deconstruct the discourses that uphold unequal power relations and to demonstrate the way in which they obscure these, it is difficult*

> *to see how this is possible without falling back upon some notion of reality or truth that the discourses are supposed to obscure."* (Burr, 2015:97)

If multiple realities and truths exist, the social constructionist challenge that there is no universal truth or reality encounters the obstacle of its own premise that no one account can claim to be the right one because like other discourses and worldviews, it is itself a social construction (Burr, 2015).

Gergen (2001, 2015) argues that constructionism is often misunderstood, and in the spirit of constructionist and critical thinking welcomes critique because it keeps important dialogues open and "*gives space to these critical voices"* (Gergen, 2015:219). He refutes arguments that constructionists neither recognise nor are able to talk about reality. He recognises pragmatically that it is convenient and useful to discuss reality but also to keep an open mind about what reality represents, and be culturally aware, and committed to the possibility of change and ongoing dialogue. Gergen describes constructionist ideas as useful "*resources*" (Gergen, 2015:225), offering pathways to new knowledge rather than creating barriers to exploration of alternative explanations.

Burr (2015) characterises the dilemmas within social constructionism as a "*realism-relativism debate*" (Burr, 2015:101), pointing out that there is no clear divide, as many realists accept the constructionist power of language, and many relativists accept the existence of an independent and real world outside the realm of discourse. The idea of discourse defining how people view the social world does not deny the existence of objects or events. The discourses relate to how an event, such as death of a loved person, is construed: whether defined by particular religious beliefs; seen as unjust, preventable and the fault of a flawed medical system; accepted as predictable and inevitable; viewed as a relief and freeing of responsibility or a tragedy, or both. Social constructionism does not limit thinking or action by insisting that a phenomenon is associated with one absolute version of reality (Gergen, 2015; 1998).

Burr (2015) describes the debate about moral relativism as in "*stalemate*" (Burr, 2015: 155). There may be theoretical difficulty in choosing sides in an absence of a "truth" to justify a moral position (Burr, 1998); however, because many constructionists are "*motivated by strong investments in social justice, world peace, and personal and planetary well-being*" (Gergen, 2015:226) the assertion that ultimately social constructionism represents a moral vacuum is unfounded. Values exist and are useful, but in a constructionist view values, like reality, are not held to be universal (Gergen, 2015). In fact, as Gergen and others insist, it is reality which "*can serve as rhetoric for inaction*" (Edwards et al., 2003:235).

Discursive psychologists have also been criticised for failing to recognise the reality of people's existence (Burr, 2015). The importance of this criticism in the case of sexual abuse and violence is clear: the implication is denial of the reality of the abuse experience of survivors. This argument misinterprets the constructionist approach, which accepts the reality and consequences of the experiences and contextualises them in cultural and social discourses. Burr (2015) distinguishes between the ontological and epistemological meanings of social construction as a helpful way of unpicking the misunderstanding. The ontological position is that real phenomena "*are brought into existence and take the particular form that they do because of the language that we share*" (Burr, 2015:105). This view refocuses on language and does not deny reality; it redefines reality as socially constructed.

3.3.3 Social constructionism as a research framework

> *"Social constructionist inquiry is principally concerned with explicating the processes by which people come to describe, explain, or otherwise account for the world (including themselves) in which they live. It attempts to articulate common forms of understanding as they now exist, as they have existed in prior historical periods, and as they might exist should creative attention be so directed*." (Gergen, 2003:15)

As a theoretical research framework, social constructionism is associated with post-modern interpretive traditions of enquiry which seek to observe, understand and explain the social world, but not to establish causal connections. Interpretive theory "*calls for the imaginative understanding of the studied phenomenon...and assumes emergent, multiple realities*" (Charmaz, 2006:126), and focuses on the creation and negotiation of meaning in peoples' lived experiences (Andrews, 2012).

Interpretivist enquiries emphasise the significance of language and often use qualitative methods involving written text or conversations. Individuals cannot see into other people's minds, but through engaging in social relationships people learn the rules of engaging with others using symbols and behaviours to understand and to make themselves understood. Interpretivist enquiry takes place in the natural world, is concerned with understanding and explaining rather than predicting, and acknowledges the interactional construction of reality. Lincoln and Guba's (1985) summary of the naturalist paradigm is reproduced here because it describes succinctly the principles underpinning the approach to this research:

Figure 5: Naturalist paradigm summary (Lincoln and Guba, 1985)

- Realities are multiple, constructed and holistic
- Knower and known are interactive and inseparable
- Only time and context bound working hypotheses are possible
- All entities are in a state of mutual simultaneous shaping, so that it is impossible to distinguish causes from effects
- Inquiry is values bound

(Lincoln and Guba, 1985:37)

Gergen's writing on therapy as social constructionism focuses on language, discourse, and the importance of dialogue. He represents members of the therapeutic community who see constructionist approaches as alternative ways of promoting change for individuals and families. These approaches resist labelling and medical models which define clients by diagnosis or by the problems they bring to therapy. Constructionist therapists and their clients engage in "*collaborative meaning making*" (Gergen, 2009:137) in the context of therapeutic relationships – the relationships they develop together in therapy. Such approaches are in harmony with feminist and social constructionist attitudes towards the research relationship, which is collaborative, aware of context and influence, focused on language, reflexive, and aware of influence and power.

There is coherence in the influence of practice experience, the adoption of a social constructionist framework, and the contribution of both to the methods described in the following chapter. Constructionist enquiry seeks to understand the perspectives of people in relation to particular experiences, events or phenomena. It does not privilege one perspective over another. In this study, such a framework is well-suited to the main aim of exploring therapeutic relationships from the perspectives of those involved in them and to addressing the research questions which seek to enhance knowledge about experiences, emotions and understandings of individuals with different standpoints involved in the same complex relational process.

The phrase therapeutic relationship in this study represents a number of interconnected qualities including the creation of a "*safe secure environment*" (Horvath et al., 2011a) and incorporating the concept of the '*alliance'* comprising a bond, agreement on goals, and collaboration on tasks. The relationship is understood to be dynamic and fluctuating. The focus on bonds, tasks and goals as relational processes provides a useful structure to present and discuss the findings, to demonstrate the connections between the three concepts, and link them with other qualities identified by participants.

To reiterate, the research questions are:

Figure 6: Research Questions

Research Question	Chapter
1. From participant perspectives, to what extent do practitioners, children and carers establish positive therapeutic relationships?	Chapter 6
2. How are the concepts of bond, collaboration on therapeutic tasks, and agreement on goals manifested in relationships in this intervention?	Chapters 6 - 9
3. How do the therapeutic relationships between children and their practitioners develop and change during the course of the intervention?	Chapters 6 & 7
4. What child, practitioner and carer characteristics are associated with establishing and maintaining an effective relationship in therapy?	Chapters 6 & 7
5. What patterns can be observed in the development and maintenance of relationships?	Chapters 6 & 7
6. What are participants' views on how the relationship helped them change?	Chapters 8 & 9

The research questions focus on investigation of a particular kind of relational space described as the "therapeutic space" (Chapter 2, Section 2.3.3.2). The idea of relational space, including the physical, social and affective dimensions, provides a helpful conceptual structure for the therapeutic relationship and all that occurs within it. In everyday life we talk about different social spaces – intimate versus personal; private versus

public. From a constructionist perspective, the space in which a therapeutic relationship occurs is as a space for dialogue, interaction and reflection. Regardless of theoretical orientation, it is conceived as a relational space constructed through interaction where young people feel safe enough to express their feelings and talk about problems.

3.4 Mixed methods approach

This study uses mixed methods to investigate a complex phenomenon. The main focus is on qualitative, interpretive inquiry but it also includes analysis of a sub-sample of scores from the Therapeutic Alliance Scales for Children (TASC) and of responses to the Carer Feedback Questionnaire (CFQ). In this section, I explain the rationale behind the mixed methods approach.

3.4.1 The acceptance of mixed methods

The mixing of methods in social inquiries was, until the 1990's, fairly unusual (Bryman and Becker, 2012a). The quantitative versus qualitative methods debate in the social sciences has dissipated as researchers have become more "*eclectic*" (Blaikie, 2010:213), practical and pragmatic (Patton, 2002), and "*free-floating*" (Bryman and Becker, 2012b:127) in approaches to investigating phenomena in the social world. The notion of "*free-floating*" methods is that they do not have to be as rigidly tied to epistemological assumptions (Bryman and Becker, 2012b). The use of mixed methods is not without opponents and is, as Patton (2002:252) suggests, methodologically and philosophically controversial. There are advocates of positivist and naturalist methodologies who hold for sound reasons that the two cannot be used at the same time. Lincoln and Guba (1985), for example, argue that there are significant points of contrast between the two paradigms and that it is impossible to hold a view of reality as "*single, tangible and fragmentable*" and at the same time believe in the position of multiple and constructed realities (Lincoln and Guba, 1985: 37). However, despite common guidelines which suggest which research designs fit best with different theories of

reality, it is possible to be ontologically consistent in social research without committing to a single methodological approach. As Blaikie notes, most data collected in social sciences inquiries begin as qualitative data:

> *"Almost all data used by social researchers begins in a qualitative form. It is only after work has been done on it, to transpose words into numbers, that quantitative data come into being*." (Blaikie, 2010: 213)

Quantitative researchers, particularly in large scale studies, tend to have no direct contact with participants. This method is practical and driven by the aims of objectivity in research design and validity, reliability and replicability of results. Data is usually collected systematically by means of pre-tested instruments and analysed using sophisticated statistical procedures. The use of numbers, the capacity for producing descriptive and possibly predictive statistics, the potential for determining causality, and the amount of control the researcher is able to exert on the data whilst remaining removed from data sources make quantitative research a powerful and preferred design in particular types of research (Bryman, 1984; Blaikie, 2010).

Quantitative methods make important assumptions about the data they collect, for example about the nature of the populations from which samples are drawn, and are able to measure and describe properties or characteristics of those populations based on data collected from a representative sample. However, they are unable to provide details about individuals. The distance which quantitative methods tend to impose between the researcher and those being researched mitigates against gathering "*rich information*" which reveals the personal experiences behind the numbers (Patton, 2002:227; Bryman, 1984). It is this combination of broad context with an intimate glimpse into the world of the social actors represented by the statistics that makes a mixed methods design appealing in social science research.

Social constructionist frameworks neither exclude nor devalue quantitative methods in empirical research. There is unquestionable value in

measurement informing, for example, policies related to issues of poverty, injustice and abuse. Questions about methods often relate to which statistics are used and how they are interpreted and presented (Iverson, 2003). Statistics are, as Gergen (2015:65) says "*one possible language amongst others."* However, it is an exclusive language, so complex that most people who do not speak it are unable to question it, including the people from whom the numbers are obtained. There is, for example, a conflict in a social constructionist analysis about how to report on measurement scales, when the scales themselves represent medical and scientific approaches to understanding. Kitzenger (1990) points out the alternative constructions of child behaviour often viewed as problematic and defined symptomatically:

> *"Activities that could be recognized as attempts to resist, or cope with abuse are, instead, labelled 'post-traumatic stress syndrome' or cited as evidence of deep psychic scarring. Such disease terminology obscures the child actively negotiating her way through the dangers of childhood. She is recast as a submissive object of victimization even by the process of intervention and treatment.*" (Kitzenger, 1990: 166; cited in Parton et al., 1995:98)

Social constructionism argues that converting observations to numbers does not necessarily make for a precise measurement of concepts: "*Numbers are no more adequate 'pictures of the world' than words, music or painting*" (Gergen, 2015:65). Further, numbers tend to depersonalise the research experience: the idea of a 'bond' in the Therapeutic Alliance Scales for Children (TASC; Shirk & Saiz, 1992) as represented by a score of one to four says nothing about the nature of the relationship, what was important about it, how each person perceived her-/himself and the other. It provides a snapshot of ratings on a positive-negative scale, providing useful information, but a partial picture.

3.4.2 The case for mixed methods

The intervention evaluation employed mixed methods: qualitative case studies to investigate process and outcome and a randomized control trial to examine effects of treatment. Mixing methods can serve a number of

purposes (Cresswell, 2011; David and Sutton, 2011). Oakley (2003) argues that mixing methods in this way can succeed, that multidisciplinary research teams have much to offer in the evaluation of interventions, and that the development of close working relationships between the service providers and the researchers in the planning stages of evaluations can allay fears of participants and service providers about the process and outcome of random allocation to an intervention. This partnership approach in the evaluation eased the process of gaining access to service user groups and agency staff.

Adopting an approach where the requirement for measurement is balanced with qualitative research also helps resolve tension related to the belief that for ethical or scientific reasons RCTs are inappropriate for examination of interventions with vulnerable service users. The combination of qualitative and quantitative methods provides a source of rich data in the context of therapeutic alliance measurements. The TASC and CFQ used in the evaluation are described in detail in Chapter 4. Data from scales are useful because they provide an outsider perspective on common characteristics and strength of therapeutic relationships. The TASC is a limited tool, however, measuring in a proscribed way, removed from the relationship it aims to describe in both administration and design, and therefore unable to access nuances of how the relationship developed.

The qualitative interviews are also limited in the sense that they are unable to provide quantifiable, generalizable data. However, their strength is their capacity to examine process in a different way: from within the relationship and in participants' language. Rather than being incompatible, the two methods are complementary. This pragmatic approach (Patton, 2002) provides context, points to areas which could be further examined quantitatively, and provides a forum where processes can be examined in a specific context.

3.5 **Reflexivity**

"*There is no single way to be, or not be, reflexive."* (Lynch, 2000:46)

I adopt in this study a methodological perspective of multi-dimensional reflexivity (Thompson and Thompson, 2008:32), involving continuous self-awareness, questioning and action on emotional as well as cognitive levels. In an inquiry involving sensitive issues, participants categorised as vulnerable, a broad context which is both deeply personal and currently political, and an area of endeavour so imbued with the concepts of relationship and embodiment, any approach lacking focus on reflexivity would be unsatisfactory, if not impossible.

Reflexivity is a much-used and controversial term (Lynch, 2000). It is theoretically dependent, in the sense that different methodologies, disciplines, and orientations view the acts and consequences of reflexivity in the research world in various ways (Lynch, 2000; Czyzewski, 1994). The concepts of reflexivity in research and professional practice are multiple and complex (Lynch, 2000:46) and the word 'reflexive' in its various forms takes on different meanings.

In everyday terms, reflexivity represents the process of thinking about the self, of looking inward at our values, beliefs, thoughts and feelings – a kind of self-monitoring of ourselves in order to better understand our position in events and what drives us. This is the notion of reflexivity as inclusive of the act of reflection. Riach (2009) describes reflexivity as: "...*a fundamental re-questioning of what is knowable within a given context, and for this questioning to inform or shape current or subsequent practice*" (Riach, 2009: 359).

Originating with Schön (1983), the capacity to reflect before, during and after action is a critical component of social work learning and practice, with distinctions made between "reflexivity", "reflective practice" and "critical reflection" (Fook, 2007:365). In social work, reflective practice helps to connect theory to practice and actions to emotions, to understand the assumptions of social, structural and personal power, and to enhance the transformative process. In relation to social work research – in both a formal and an informal sense of knowledge creation – reflexivity involves looking

inwards and outwards simultaneously "*to recognize the connections with social and cultural understandings*" (Fook, 2007:366). The reflexive researcher is in tune with her own stance, beliefs, assumptions, experience, and knowledge as well as how she feels and presents at all stages of the project. She understands the importance of context, and the "*social processes that impinge on and influence data*" (Becker et al., 2012:408), and knows that methods also influence the answers. She also acknowledges that "*reflexivity may be embedded in the moment"* (Riach, 2009:258). Becker et al. (2012) define reflexivity in research as a process which:

> *"…involves reflection by researchers on the social processes that impinge on and influence data. It requires a critical attitude towards data, and recognition of the influence on the research of such factors as the location of the setting, the sensitivity of the topic and the nature of the social interaction between the researcher and the researched.*" (Becker et al., 2012:408)

Postmodern and social constructionist approaches to research and social work practice embrace reflexivity and highlight participant voices, challenging dominant discourses about what constitutes knowledge, and in turn what constitutes 'best practice'. There remains an imperative for services offering interventions, including therapy, to adopt techniques, tools and programmes which have demonstrated their effectiveness using what are still considered to be the most robust methodologies. The ontological premises of these approaches, which include concern about undermining objective distance, formal concepts of reliability and validity, and the principle of universality of truth suggest that there is little room for reflexivity. However, in engaging in research about therapeutic interventions it is important to take account of the wider picture and discourses which position individuals as in need of particular kinds of help and support. Social constructionism enables the researcher to remain attuned to the social work values of reflective, anti-oppressive and holistic practice, and to strive to create a different kind of knowledge about therapeutic interventions.

Reflexivity in research is not a magic wand, and has limitations. There are important questions for the researcher and the practitioner: in both cases, for whom are we doing this? Who is being empowered and for what purpose? How does the context affect the process and outcome? How do service users/research participants view the social worker/researcher? Reflexivity before, during and after interviewing helps researchers address these questions; if it is absent, the risks of harming participants or misinterpreting their responses increase. Becker's et al. (2012) definition of reflexivity concisely sums up this concern:

> *"In the absence of reflexivity, the strengths of the data are exaggerated and/or the weaknesses underemphasized*." (Becker et al., 2012:408)

In the context of this study, the reflexivity model conceptualized is similar to Wasserfall's (1997:151) description in which the researcher develops

> *"…continued self-awareness about the ongoing relationship between a researcher and informants, which is epistemologically useful: the researcher becomes more aware of constructing knowledge and of the influences of her beliefs, backgrounds and feelings in the process of researching*."

This model necessarily addresses issues of authority and power. However, it is difficult to escape the "*interpretive authority*" of the researcher as it is the author who ultimately controls the interpretation and the final representations (Wasserfall, 1997). Transparency in research, to self and others, helps avoid the risk of "*illusion of democratisation*" (Burr, 2015: 176) of the research relationship. Reflexivity, self-awareness, and honesty acknowledge that the author's social/political beliefs and experiences bear on interpretation and analysis, and it is important to remind ourselves that these may not be views shared by participants.

3.6 **Chapter Summary**

This chapter has presented the theoretical and experiential framework underpinning the research approach, explained the use of mixed methods to address the research questions and considered the important role of

reflexivity throughout the research process. The following chapter describes the methods used for data collection and analysis, reflects on the positive aspects as well as the challenges and dilemmas in all stages of the research and details the ethical issues.

4 Chapter 4: Methodology Part 2, Methods

"…open your eyes… and then open your eyes again."
Terry Pratchett (2003, The Wee Free Men, Chapter 2)

4.1 Introduction

This chapter describes the methods used in the *MMW* study. Methods of data collection and analysis are detailed, including decisions about access to participants, and quantitative and qualitative sampling processes. The role of agency practitioners as gatekeepers is explained. The topic of semi-structured interviews with vulnerable people, role of researcher reflexivity and sensitivity, and impacts of the process on researcher and participants receive particular attention. The chapter also reflects on the ethical issues associated with sensitive research and the complexities of interviewing a diverse sample.

The first part of the chapter explains the sampling process, data collection and analysis related to the quantitative data and provides a description the *Therapeutic Alliance Scales for Children* (TASC) and the *Carer Feedback Questionnaire* (CFQ).

4.2 Quantitative method: data collection and analysis

The quantitative data and analysis are included in the study to:

- Provide context for the qualitative data in the wider community of young people and therapists in therapeutic relationships in this intervention,
- Examine alternative practitioner and young person accounts in a way that complements the qualitative methods
- Position the carer responses in the context of the wider community of carers involved with the intervention,
- Answer questions about change in relationship over time
- Provide another dimension to the questions about how participants show bond and agreement on tasks.

4.2.1 Therapeutic alliance scales for children (TASC)

4.2.1.1 Sampling

The *Therapeutic Alliance Scales for Children (TASC;* Shirk and Saiz, 1992) were used to measure the strength of the therapeutic alliance between children and therapists in the evaluation. The *TASC* were administered to practitioners and children aged seven and above at two points. The first point (T1) was after the third therapeutic session, and the second point (T2) was six months later, regardless of whether or not the child had finished the intervention. Some children, therefore, may no longer have been attending the service at T2. The scales consist of twelve items scored on a four-point Likert scale from 1 (Not at all) to 4 (Very much) (Appendices C and D).

Collecting data from the TASC questionnaires for the Evaluation involved practitioners and young people completing the relevant scales anonymously and returning them directly to the Evaluation team. The quantitative sample in this study comprised raw TASC scores from scales completed by 148 children/young people and their workers between 15 January 2013 and 5 March 2014. I acquired these data in date order from the spreadsheet compiled by the evaluation team, using the day the TASC T1 (Time 1) score was recorded. The original plan was to use the first 100 sets of scores obtained in the evaluation's data collection phase, but as less than half of the T2 scales were completed, I took the decision to increase the sample size. The scores were obtained from the evaluation spreadsheet, and dates of birth and gender were obtained from a spreadsheet derived from the Agency electronic recording system. No names or addresses were included in spreadsheets, and confidential information was stored at the University in a file only accessible by the researcher and first supervisor, also a member of the evaluation team.

4.2.1.2 Structure and design of TASC

The TASC are based on Bordin's (1979) concept of therapeutic alliance. In developing the scales, Shirk and Saiz (1992) focused on affective (bond)

and task oriented factors. Their preliminary research had failed to find a single, "*global child therapy participation factor*", and instead pointed to the existence of three – two of them having an "*affective orientation"* (negative and positive) and the third relating to *"therapeutic tasks*" (Shirk and Saiz, 1992:718).

The TASC consist of three subscales measuring affective orientation to therapy (the bond and negativity scale respectively) and collaboration on therapeutic tasks represented by talking about problems (verbalisation scale). The affective subscales consist of items informed by experienced clinical child psychiatrists and psychologists (Shirk and Saiz, 1992:718), and include statements about, for example, spending time with a doctor. The language was adapted for use in the evaluation to be appropriate for children and young people involved in the intervention. For example, rather than "I like spending time with my doctor", the item on the scale used in the evaluation reads "I like spending time with my worker".

The subscale representing child and youth therapeutic activity as reliant on verbal activity was so described because it was suitable for the context (hospital setting) in which the TASC were developed, although Shirk and Saiz (1992) recognised that other "task dimensions" were available. The verbalisation subscale items in the *TASC-revised (Youth version)* utilised in the evaluation are ambiguous in the sense that the verb "work" is used, encompassing a range of activities. An example of an item on the verbalisation scale is "I work with my *Agency* worker on solving problems in my life."

Shirk and Saiz (1992) created two versions of the *TASC*, therapist and child, to be administered at the same time. The therapist version (Appendix C) consists of the same items, but orientated towards the therapist perspective. The parallel question about spending time with the practitioner thus reads as "The child likes spending time with you", and the item relating to working on tasks is "The child works with you on solving problems in his/her life."

4.2.1.3 Reliability

Shirk and Saiz (1992) found that the therapist scales demonstrated adequate internal reliability across all three subscales (Chronbach's alpha (α) for bond, negativity and verbalisation scales were 0.88, 0.72 and 0.87 respectively). The child subscales demonstrated adequate reliability for bond and negativity subscales (Chronbach's alpha (α) was 0.72 and 0.74 respectively) and partial support for reliability of verbalisation scale (Chronbach's α was 0.67) (Shirk and Saiz, 1992:719; Cahill et al, 2008: 320).

4.2.1.4 Validity

The question of validity with reference to the TASC is whether the scales measure therapeutic alliance as intended. No details are available regarding face validity, concurrent validity, or construct validity. However, therapist ratings on the therapist version of the TASC were compared with their ratings on a global measure of participation in therapy (an adapted version of the *Menninger Collaboration Scale;* Allen, 1984, cited in Shirk and Saiz, 1992:719). It was found that therapists' ratings of child participation were significantly related to TASC ratings on bond and negativity scales, indicating support for convergent validity of the measure (Brymon, 2012: 172).

4.2.1.5 Inter-correlations

As expected, Shirk and Saiz (1992:719) found an inverse correlation between the bond and negativity scales for both child and therapist instruments. In other words, children who provided a higher rating on the items on the bond scale gave a lower rating to items on the negativity scale, supporting the validity of the questionnaire. They also found a "*moderate degree of convergence*" (Shirk and Saiz, 1992: 719) between therapist and child ratings on the affective scales, indicating that children and therapists tended to agree on the nature of the therapeutic relationship. Finally, the

study found a positive correlation between verbalisation and bond items, although the evidence was stronger in the therapist scales. This finding supports clinical observations that the more positively children view their relationships with therapists, the more likely they are to participate in working on their problems. Measuring causality is impossible as both aspects were measured simultaneously.

4.2.1.6 Questions

In this study, analysis of TASC data addresses two questions.

1. The *Therapeutic Alliance Scales for Children* aim to measure the strength of the therapeutic alliance from two different perspectives. Analysis of TASC scores complements the qualitative part of the study in responding to the question of how practitioners and children view the relationships they formed, but in a different way.
2. The scores can be analysed to assess the direction of change, if any, over the six months between T1 and T2. Again, this analysis complements the qualitative analysis in providing a different kind of view on relational change during the course of the intervention. With only two data collection points, subtle differences in the alliance which might be associated with particular phases of the therapeutic work cannot be explored using TASC data, but can be investigated using qualitative methods.

4.2.2 Carer Feedback Questionnaires (CFQ)

Work with safe carers is an integral part of the intervention. The CFQ enabled the Agency to gather feedback on the carer intervention, and the researcher to consider how parent-practitioner relationships differed from child-practitioner relationships. This section describes the value and limitations of the CFQ in responding to the research questions.

The intervention acknowledges the important role of safe carers in protecting children and supporting their recovery, and offers carers an initial assessment followed by individual sessions focusing on their own identified needs, joint sessions with their child, or both. Intervention guidance

recommends that safe carers have their own workers for individual sessions, and engage with the child's worker in joint sessions. In either case, carers are asked to enter into a working relationship with an *Agency* worker to support the therapeutic goals of their child.

4.2.2.1 Sample

CFQs were administered to carers or parents who had individual carer sessions or joint sessions with their child. Completion was optional. The sample comprises 86 responses from CFQs completed between 27 June 2013 and 20 March 2015. The original plan was to examine the first 100 completed, specifically questions relating to the carer/parent relationship with their worker and carer comments. However, the total number returned within the timescale was less than 100, so all were included. The following paragraphs describe the development of the CFQ and its use in the context of this study.

4.2.2.2 Assessing the relationship

The question arose in the evaluation of how to assess the relationship formed between safe carers and their workers. Data about the strength of their relationships could not be captured in the same way as data about children's relationships. There is an argument that as the carer service is not therapeutic and the children's service does not offer family therapy, carer-worker relationships do not constitute 'therapeutic relationships' either in concept or in practice and therapeutic alliance scales for adults are inappropriate. Other issues related to the administration of a single alliance scale were identified:

- Carers are offered unique and variable services. Although all work focuses on the best outcomes for the child, carers present with various needs and wishes related to contributing to children's recovery. Not all carers receive the same level of input, and some receive none.

- Timeframes are flexible. Carers may have six - eight sessions, followed by joint sessions with their child if appropriate. Carers may or may not begin sessions at the same time as the child and joint sessions happen when (and if) child is ready. The administration of scales for child and carer therefore cannot be scheduled to coincide. To conduct a meaningful comparison of data in a group, members of the group should be receiving the same services.

- The intervention guidance suggests that carers have their own workers for individual sessions, but must see the child's worker for any joint sessions. Carers therefore may interact with multiple workers.

There are few scales specifically designed to measure the relationship between carers and therapists in therapeutic interventions with children. In treatments where the parent or carer is in receipt of a therapeutic service in parallel with their child's treatment, such as Parent Management Training (Kazdin and Whitley, 2006) the development of a parent/carer-therapist alliance is more likely. In this intervention however, the focus is the child, and the aim of carer involvement is to support the work with the child.

4.2.2.3 Designing the CFQ

The evaluation team and the Agency agreed on development of a multi-purpose form to gain feedback and information on how carers perceived relationships with practitioners (Appendix E). The evaluation team collaborated on development of the CFQ; my specific contribution was the addition of Question 3 which asked parents to rate relationships with their workers in line with Bordin's definition of the therapeutic alliance. The CFQ comprised four questions. Questions 1 and 2 asked carers to indicate on a scale how they felt work with the agency helped them; question 3 enquired about the relationship developed with their worker. Carers were invited to rate their agreement with relationship statements which focused on affective,

goal-orientated and task related elements. Question 4 invited open comments on their experience of the carer service.

CFQ questions 3 and 4 are relevant to this study, and findings related to 3a ("My worker and I agreed on goals of the work") and 4 are incorporated into Chapter 9. The questionnaire has not been tested for validity or reliability so it would be methodologically unsound to make assumptions about its ability to examine the construct of therapeutic alliance. It is possible, however, to make cautious statements about aspects of the relationships from carer perspectives. However, even such limited analysis provides a backdrop to the qualitative findings from the small number of interviews with carers, and places these in the context of the wider group of carers who engaged with the intervention.

4.3 Qualitative Methods – data collection and analysis

The remainder of the chapter pertains to the qualitative part of the study, the major focus of this thesis. The sections below describe access, sampling procedures and issues raised, and discuss research with vulnerable participants and related ethical considerations. Discussion of matters related to interviewing children and adults on sensitive topics in the context of an evaluation and a therapeutic intervention follow. This discussion includes thoughts on the concept of "ethical symmetry" in research, power and empowerment in research relationships, and confidentiality and informed consent. Risks and benefits to participants and researcher are examined. The final section focuses on the development of themes in the data using the method of framework analysis.

4.3.1 Sampling procedures and challenges

4.3.1.1 Teams involved

Three teams providing the service and not involved in other qualitative aspects of the evaluation agreed to participate in the MMW study. Each team agreed to refer up to four young people who had finished the

Intervention in the previous six – eight weeks. A protocol was established to manage referrals to the study of appropriate cases in line with the gatekeeping process. The invitation to take part in the research was an "opt-in" process, in which potential participants received information directly from practitioners and signed consent forms for the researcher to make contact. Teams had no control on how many cases were referred within the original seven month period set for data collection, or how many young people would finish the intervention, agree to be contacted, and agree to participate, and referral rates to the study were initially slow, unpredictable and inconsistent. The following chapter provides additional details on teams involved.

4.3.1.2 Sampling by convenience and self-selection

The sampling method was convenience sampling. The original plan was for purposive, or *"purposeful"* (Patton, 2002) sampling to allow for "*detailed investigation of social processes in a specified context*" (Ritchie and Lewis, 2003:79). The context in this case is therapeutic intervention, delivered according to agency guidance, within a specified timeframe, and under evaluation. However, the reality of the research context did not enable a sampling procedure that would yield a purposive sample. Convenience sampling is one that is "*simply available to the research by virtue of its accessibility"* (Brymon, 2012). In order to ensure that the sample size was sufficient, an early decision was taken to interview on a first come-first serve basis. It was acknowledged that this method meant that there was no control over demographic characteristics such as age, gender or ethnicity, and that therefore the sample could not be said to represent the population from which it was drawn. The gatekeeping responsibility of the teams, an essential part of the access and sampling process, posed an additional challenge.

4.3.1.3 Access and Agency Gatekeeping

Due to the perceived vulnerability of the young people involved, teams participating in the study acted as gatekeepers for the children who were

potential participants. The gatekeeping terms were consistent with exception terms of the evaluation which enabled the Agency to make decisions to opt families out of the research. Opt-out reasons included, for example, ongoing or new trauma or mental health issues, change in circumstances which could affect the capacity of children or carers to participate, or safeguarding concerns.

Teams did not put forward children and carers as potential participants for the study if it was felt that taking part would jeopardise their health and safety, if the case was closed after assessment phase, or if the family had dropped out and not completed the intervention. The first decision category was intended to protect children and families from re-triggered trauma or other harm which may occur as a result of participation in research, and the second and third were designed to avoid harm to young people who had not received the full intervention, and to eliminate families who were perceived to have been involved for too short a period to have developed relationships with workers.

Gatekeeping is an important process in research with vulnerable groups because of the additional layer of protection it provides by professionals who understand how individuals may be at risk if they agree to be study participants. It also raises sampling issues. Professionals are busy and may lack time or forget to pass study details on. Gatekeeping by nature involves professional judgment, and therefore contributes to sample bias. Gatekeeping potentially deprives families of the opportunity to make their own choices about participating. I am aware from experience as a practitioner in similar circumstances of the difficulty in making such decisions and the additional pressure which comes with the awareness of being evaluated.

4.3.1.4 Steps taken to address sampling challenges

I was unable to address the sample bias caused by self-selection and convenience sampling; however I was able to develop strategies in an effort

to mediate against the impact of sampling problems related to gatekeeping, sample frame and timing. I reassured practitioners that the goal of this study was to contribute to a deeper understanding of the nature of relationships, not to evaluate practice. I was open about my social work experience of the difficulties of engaging with young people and their parents and my understanding of relationships as complex, unique, and influenced by many external factors. I reinforced the message about confidentiality and anonymity. Finally, I fed back to the teams after completing interviews that the people interviewed had participated voluntarily, were not harmed, and that none had wanted to withdraw or complain about the questions or process. These strategies aimed to reassure practitioners that the research process was non-judgmental, sensitive to individual circumstances, and complicit with principles and practice of informed consent.

I was also unable to influence the number of referrals and progress in the intervention. However, I liaised regularly with the relevant administrators and team managers to remind them that I was still collecting data. I also thanked them each time they referred someone to the study – this represented a genuine acknowledgement of the time and effort involved on top of the requirements the full evaluation placed upon teams.

4.3.1.5 Issues of representativeness and generalisability

In qualitative research it is difficult to achieve the representativeness of quantitative methods (Khan and Fisher, 2014) but as qualitative studies ask different kinds of questions, the expectations of generalizability, or external validity, are also different. As Khan and Fisher (2014:19) point out,

> *"…while qualitative data are frequently not representative in terms of the people that are sampled, they are often much more representative in terms of the situations that are studied."*

As an applied research study exploring human relationships in a field of practice, this study has the capacity to contribute knowledge of interest and use to professionals and policy makers. It is the richness and depth of the inquiry, the attention to detail, the care taken by the researcher to focus on

analysis of messages delivered by participants that contribute to the validity and meaningfulness of small, qualitative studies (Patton, 2002). Acknowledging subjectivity, maintaining reflexivity, incorporating multiple perspectives and awareness of context help ensure quality of qualitative, constructionist research.

Sample bias, sample size

Issues of bias and sample size in qualitative research are complex, and permeate the research process. It is difficult to control or identify the nature of sample bias and size in situations where the researcher does not have the autonomy to manage who takes part. The sampling method and related issues determine that findings in this study are not generalisable to therapeutic relationships developed in other interventions or perhaps to relationships developed in other teams providing the service (Brymon, 2012). The value of this study lies in the complementary information it provides to the evaluation, the insight into relationship processes, and potential for comparison with similarly focused studies. Participants were self-selected, and it is possible that their motivation in itself says something about how they viewed the relationships they developed. In the reporting and interpretation of their responses care must be taken to note that, whilst there are many voices which have not been heard, the insight into the process of relationships in therapy from multiple perspectives is valuable in providing a "*sense of the rich texture of how social processes work"* (Khan and Fisher, 2014:18).

4.4 Ethical considerations

4.4.1 Introduction

This is a complex study involving a number of stakeholders: service users, parents and carers, the agency developing and providing the service, and the evaluation team. Research with children raises particular ethical issues (Brymon, 2012); much of this section therefore refers to considerations

relevant to children and young people. The study is committed to the notion of 'ethical research' and to the view that the welfare and safety of children must not be compromised for the sake of research. In discussing the key ethical considerations in this research, the notion of "ethical symmetry" is explored from two perspectives, considering Christensen's and Prout's (2002) discussion of ethical symmetry in relation to interviewing children, and ethical symmetry as part of the relational healing process for sexually abused young people. Finally, the possible risks and anticipated benefits for participants and researchers are discussed. The section begins with a brief discussion of what it means to undertake ethical research.

4.4.2 Researching vulnerable groups

"First do no harm." (Brown, 2014:3260)

Researchers have a responsibility to participants to conduct themselves and their research in a way which respects participants and their contributions, protects them from harm, offers clarity about confidentiality and its limits, and is open and honest about the purpose, process and potential benefits of the study (Banks, 2012: 58-59). Ethics in general refers to moral principles and how we apply them; in research this extends to the principles underpinning respect for participants and the preservation of their safety and well-being. The concept of harm in research is no longer confined to the narrow understanding of physical harm in the context of medical research: researchers now commit to a more comprehensive definition in the context of social research. In 'real world' research, and especially in research involving intrusions into the lives of potentially vulnerable people, ethical considerations "*have a particular resonance"* (Lewis, 2003:66) and there is a mandate for ethics to be a "process" rather than separate component (Liamputtong, 2007; Morrow and Richards, 1996). It is not enough for the research community to minimize the relative power embedded in the position of researcher by merely complying with the legal and moral obligation to protect participants from "*unwarranted intrusion by researchers*" (D'Cruz,

2000:1.1). In social research which embraces interpretivist principles of reflection, researcher reflexivity allows for the negotiation of power and the co-creation of knowledge within the research relationship (D'Cruz, 2000).

4.4.3 What is ethical research?

Ethical research

> *"…is about the legal and moral protection of subjects from the researcher's techniques of inquiry. The research relationship is constituted as one between 'powerful researcher' and 'powerless researched'. Alternative views which foreground the researcher (and informants') subjectivities as positioned sites of power challenge the unitary identities of 'more powerful researcher' and 'less powerful researched'."* (D'Cruz, 2000: Abstract)

The methodological approach in this study is positioned with D'Cruz's '*alternative views*' interpretative research. Ethics in this context encompass conversations about reflexivity and sensitivity as they relate to the entire research process, from planning to dissemination, although it is in the interviewing phase where ethical practice is most directly experienced by research participants. The following paragraphs describe the process of obtaining ethical approval for the study.

4.4.4 Obtaining ethical approval

Ethical approval is a necessary and justified part of the research process, and although the maxim "do no harm" seems unambiguous and direct, ethical decisions often are not. They are complicated by competing values and moral dilemmas, and influenced by the research context and researchers.

Participants are protected from potential harm by the Health Research Authority and by discipline specific statements or codes of ethical practice (e.g. British Sociological Association Statement of Ethical Practice, 2002) and more locally by organisational research ethics committees. In addition, researchers have "*an obligation to conform to the ethical standards of the society in which they conduct their work*" (SRA: Social Research

Association, 2003:15). Researchers are bound by legislation related to data protection (DPA1998), privacy, and human rights (HRA 1998). The outcome and process evaluation by its nature carries considerable ethical responsibility to be clear about who will be helped, to ensure no harm, and to commit to policy and practice of informed consent (Gambrill, 2011). As a contributing part of the evaluation this study heeded the same guidelines and required ethical approval in its own right. As a doctoral research project, the study was also subject to Durham University's departmental ethical procedures, and as a study involving a vulnerable group it was essential to satisfy conditions of informed consent, confidentiality, anonymity and avoidance of harm to both participants and researcher. University ethical approval was granted in April 2013.

Ethical approval was also sought from the Agency providing the intervention. As the Agency works with vulnerable children and families and has responsibility for access to research participants, the approval process is comprehensive and rigorous. Agency approval was granted in September 2013.

Qualitative research involving face to face interaction inevitably affects participants because it is a relationship; research relationships are both a source of data and a medium for change. The research relationship is subject to boundaries and guidelines appropriate to the topic, the participant characteristics and circumstances, and the research goals. These issues are discussed in the paragraphs below.

4.4.5 Sensitive nature of the research

"Sensitive research" is research which is "*impacted by, and has an impact on, the social context in which the research takes place"* (Brewer, 2012: 69). On a superficial level, this study does no more than ask children and adults how they got on with another person. It is clear, however, that from the participants' perspective the research represents an intrusion, although not necessarily an unwelcome one, into their lives, and the study's context makes the research topic sensitive. The process of protecting participants

begins with providing information in advance and ensuring informed consent to make sure that participation is viewed as an invitation, not a requirement.

The study represents an exploration of the kind of "*private space*" referred to by Liamputtong (2007:2). It was important to acknowledge and understand the events and consequences which brought the research participants together, and to assess the impacts of the study on all involved (Dickson-Swift et al., 2007). In designing materials and topic guides, I was mindful of the possible impacts of the child's and family's experiences of therapy. Consideration was also given to the sensitivity of the topic for practitioners, their journey with children and parents, and the ongoing evaluation.

Sensitive research places responsibility on the researcher to be vigilant and maintain a caring approach throughout the research process. Participants were reminded that they did not need to answer any questions, and that they could have a break or withdraw altogether. Alternative account-giving tools (activity sheets, drawing materials) were offered to children, but were rarely used. Creative tools should be used with care and not assumed to be innocuous activities (Leitch, 2008). Drawing or visual prompts might trigger emotional responses as questions might. The research relationship, no matter how brief, is a dynamic one, and it was important for me to be empathic, mindful, reflexive (Davis, 1998) and alert to the signs of participant anxiety or distress, but also to positive signs of enthusiasm, joy or relief.

4.4.6 Ethical symmetry, vulnerability and strength

For some participants, thinking and talking about relationships in the context of therapy related to CSA carries the potential to trigger thoughts of the original trauma. This is not an inevitable consequence of the research process, but the vulnerability of children and carers for re-traumatisation must be recognised. Social researchers are focusing less on the "impersonal" nature of measuring children's lives in order to concentrate on hearing their views and perspectives (Woodhead and Faulkner, 2008). It is possible to do this ethically and to avoid causing harm, distress or unnecessary intrusion.

The idea of “ethical symmetry” (Christensen and Prout, 2002) portrays ethical principles as applied in the same way to children and adults. In other words, researchers adopt an ethical stance in their relationships with all participants regardless of age whilst paying particular attention to children’s situations in the real world. This ethical position is reflected in the interviewing approach which begins with the premise that children have valid contributions to make to research, but that adult researchers’ preconceptions of children’s communication, understanding and experience of the world may obscure what they have to say (Punch, 2002).

Children are currently considered vulnerable by virtue of their age, a status that confers upon adults a duty of protection. Children’s vulnerability in the legal arena is symbolised by the status ascribed to child witnesses, for example, and the special measures which may be applied for children giving evidence in court (Youth Justice and Criminal Evidence Act 1999; Wade, 2002). The change in attitude towards children from viewing them as unreliable and often incompetent witnesses (Ceci et al., 2002) to credible witnesses parallels the recognition that children and young people have rights, are competent, make decisions and are individual participants with valid views about the provision of services rather than passive recipients (Morrow and Richards, 1996).

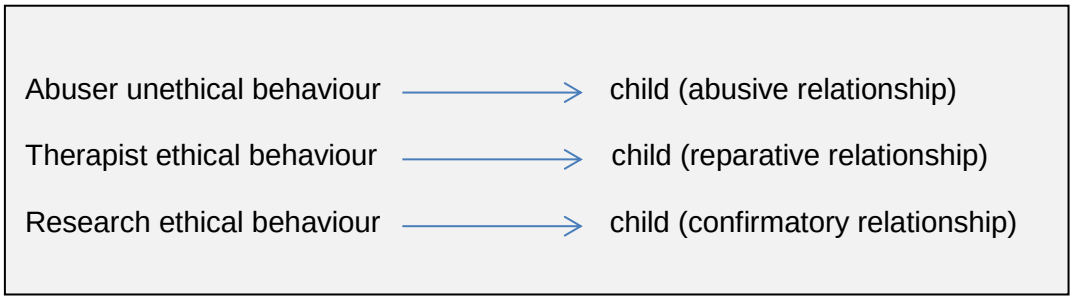
It is important to recognize, however, that vulnerability is not an absolute state. It is a social construct which alters as social, political, cultural and moral attitudes shift (Moore and Miller, 1999; Liamputtong, 2007). This study takes the view that vulnerability is a flexible construct – people may be more or less vulnerable at certain times in their lives and in particular circumstances. The concept adopted here is of a dual responsibility to protect people at times when they are vulnerable and to support their strengths. Ironically, the paternalistic welfare state concept of vulnerability is potentially unethical if pursued uncritically and unreflectively (Diamantides, 1999). Moore and Miller (1999:1035) use the term “*doubly vulnerable*” to describe individuals who may “*simultaneously experience more than one*

factor that diminishes autonomy" and children who have experienced trauma fit this definition. Vulnerability as not absolute, however, is illustrated in the UK by the position of young abusers/people with harmful sexual behaviour who can be subject to conflicting constructions simultaneously, as both vulnerable and responsible for offending.

'Vulnerability' as an ascribed characteristic is also double-edged, and includes the potential for others taking responsibility *"away from"* rather than taking responsibility "*for"* vulnerable individuals (Christensen and Prout, 2002:479). It is important not to generalise all children to a single group, and to recognise individual strength and resilience. Asking important questions need not trigger negative reactions, but failure to ask can prove detrimental in terms of understanding children's experiences and influencing practice and policy in the long term (Becker-Blease and Freyd, 2006). Researchers can consider the vulnerability and strengths of individual participants without making assumptions based solely on status as child, adult, or trauma survivor. In this study, children's common status as having experienced abuse means neither that they are all the same, nor that their defined status as vulnerable renders them incapable of engaging in research conversation. The "gatekeeping" process established was part of respecting individual children and carers and acknowledging their strengths and vulnerabilities.

Ethical symmetry can also be portrayed relationally, as part of the process of confirming children's experience of non-abusive relationships. The figure below illustrates the place of ethical research behaviour on the continuum of children's healing from the consequences of "unethical" abusive behaviour.

Figure 7: Ethical and unethical relationships



A significant role for the practitioners working with sexually abused children was developing a relationship in therapy which would facilitate the capacity to work on problems associated with the traumatic impacts of sexual abuse. Therapeutic "ethical engagement" calls upon therapists

> *"…to consider their use of professional knowledge, subjective experience and position, and to attend to issues of power and cultural difference."* (Arthington and Boston, 2014, Kindle edition, loc. 4063)

Practitioner approaches characterised by the "ethical" qualities of respect, care and devolvement of power and control help counteract the "unethical" characteristics of abusive relationships involving harm, betrayal, misuse of power and control, silencing of the child's voice and will, and lack of respect.

4.4.7 Power and empowerment: age and understanding

The research interview cannot represent a conversation or interaction where there is complete equality because it is the researcher who defines the question and the methods (Kvale, 1996). There is therefore a power imbalance which may entail participants, regardless of age, disclosing more than they mean to, answering questions they do not want to answer, or feeling that their choices are limited (Liamputtong, 2007:27). There is particular danger in interviewing children who in most cases view adults as knowledgeable people with power. At the same time, awareness of power and of children's attribution of power to adults, risks drawing interviewers into over-simplifying or avoiding difficult questions because of assumptions made about young peoples' ability, experience and knowledge. Researchers need strategies to deal with participants' disclosure of extraneous information – strategies which include ensuring that the discussion remains on track, and that confidentiality and anonymity are preserved. This is part of the researcher's ethical accountability and responsibility to the participants – the *"ethical framework"* for dealing with issues which arise in interviews (Patton, 2002:406). These issues include dilemmas which might arise in relation to

confidentiality and informed consent, which are explored in the following subsection.

4.4.8 Confidentiality and ongoing informed consent

Confidentiality and informed consent are key components of the practice of ethical research, and in this study were provided through participant information sheets and consent forms *(Appendices A and B)* and verbal assurances. Data collection and storage complied with the Data Protection Act 1998 and with University and Agency requirements. The principles of society's responsibility to safeguard children's wellbeing and protect them from harm extend to research, which raises potential dilemmas related to confidentiality and consent. Confidentiality cannot be absolute in these circumstances, and consent must be informed. Children, depending on age and development, are able to give consent and understand confidentiality (Chu et al., 2008) but to ensure that consent was truly informed in this study, information sheets and consent forms were designed to be *"simple, straightforward and understandable"* (Patton, 2002:407). In written material and verbal discussions, explanations of confidentiality included clauses detailing the limits of confidentiality as they related to disclosure or suspicion of risk of harm. The language and phrasing of the limited confidentiality clause needed to be brief but clear, and appropriate to age and ability (Fargas-Malet et al., 2010). The words "private" and "confidential" have different meanings and consequences, and for children and young people might be confusing, and the concept "risk of harm" may be variably interpreted, even amongst professionals. All information and consent forms were similar to forms used in the evaluation, which had been approved by the Agency and were in accordance with Agency policies and procedures. Therefore, the concept of limited confidentiality and the words and phrasing used in this study were familiar to the participants.

Participants had agreed to take part in the evaluation data collection, but as this was a separate study additional consent was required. ESRC (2006) guidelines are clear about the importance of continuous consent, stating that

although the process may begin with a consent form, it does not end there. From participants' perspective, informed consent includes understanding the purpose of the study, how data is collected and stored, who is researching and funding the research, who has access to personal information and interview data, what participating will mean to them, and how findings will be disseminated (Lewis, 2003; Patton, 2002). Ongoing consent was obtained by verifying that participants understood all the information provided before signing consent forms and commencing the interview, checking verbally and monitoring individuals' responses and presentation throughout the interview.

4.4.9 Risks and Benefits to participants

4.4.9.1 Children and Parents/Carers

Asking children and adult questions related to traumatic events need not entail risk, but in the event of unexpected distress revealed in interview, information about additional support was available. It is important to note potential benefits. Chu et al (2008:54) found that, when asked about participation in their research, the majority of children reported a "*positive cost-benefit"* ratio, regardless of trauma history. Research into the area of CSA, which is politically controversial and immensely private, falls into the category of "*socially sensitive research"* (Brewer, 2012:71) which is likely to have social or political impacts beyond any benefits to those who take part. The findings of this study have greatest impact for future service users and therapy providers. In reporting on the perspectives of those involved in therapy on their experience of therapeutic space, the study will promote a deeper understanding of the nature of relationships as they are experienced by children, their carers, and their workers.

There is also a perceived benefit to participants who are valued for their contribution and have the opportunity to express their views. All participants chose to be included and to report their experiences, and were free to respond as they wished to questions. Participants were respected and

thanked, and gift cards provided in acknowledgement of their time and sharing of information. Different groups of participants may experience unanticipated rewards: people may welcome the opportunity to tell someone outside the family about how they got on with their workers, parents and carers also may appreciate reflecting on their child's relationship and observed progress.

Finally, genuine motivation for collaboration in which children and young people act as partners in solving a puzzle rather than as objects of study helps to remove barriers created by differences in age, status and role. Setting what Leitch (2008:53) describes as a "*respectful yet natural and collaborative atmosphere for the research tasks*" is more likely to facilitate development of a comfortable research relationship and be of benefit to all participants.

4.4.9.2 Practitioners

Practitioners are accustomed to dealing with emotional material in therapeutic sessions. It does not follow, however, that discussing a relationship which may at times have been intense and fragile does not affect them, and the context of feeling judged as part of the evaluation process could not be ignored. To address this possibility, I reminded practitioners of confidentiality and boundaries, and that this study was seeking their perspectives rather than evaluating practice. My personal experience helped me understand concerns about being judged and also the challenges and rewards of their work. The anticipated benefits for practitioners were in being provided a forum to share professional and personal perspectives on a fundamental aspect of their practice in the knowledge that their contributions were of value to the research, to reflect on what made the relationships with children/young people/parents more or less effective, and to express views which they might not otherwise have an opportunity to air.

4.4.9.3 Researcher

Undertaking sensitive research also has implications and meaning for the researcher, and poses personal and ethical challenges (Dickson-Swift et al., 2007). Researchers assessing the potential for risk to their own safety as well as their participants are likely to find similar possibilities for breached boundaries, emotional responses, compromised physical safety, ethical dilemmas and secondary trauma. In practical terms, many qualitative social researchers, including doctoral students, travel and work alone.

Dickson-Swift et al. (2007) found a number of issues which affected researchers during all stages of the research: at the point of "*entering the lives of others",* during interview, transcription and analysis phases, and on reflection, after the research was completed. Issues which particularly resonated with this study included rapport-building, feelings of care, concern, humility and humanity evoked during the interview process. Emotional responses to trauma-stories were less of an issue because I did not have access to personal background information on participants except what they chose to disclose, and because we were discussing the therapeutic relationships which were positive. Nevertheless, as a social worker/parent/woman I was aware of emotion and pain in the context of CSA, so this sensitivity was always in the background. Witnessing the distress of others can engender in the observer feelings of powerlessness and vulnerability, and reflection can be a path to self-knowledge – not always welcome or comfortable. Seemingly small but frustrating experiences such as research participants withdrawing, time limitations, or lack of referrals can mount up and feel overwhelming and in a small-scale study loss of confidence and feeling of letting oneself and participants down can be significant. In these instances, the importance of self-care strategies to cope with set-backs and negativity is clear.

Undoubtedly the potential benefits outweigh the risks. The opportunity to have a different kind of conversation with participants representing the families and colleagues with whom I had previously practiced was

professionally and personally rewarding. Although the goal of the study was to gain the perspectives of participants, underlying and influencing this process is the perspective of the researcher. Davis (1998) suggests that the presence of difference encourages researchers to use their own perspectives to help understand the differences between researcher and participant cultures in a mutual exchange:

> *"The clash between the culture of the researcher and the researched is believed to allow the different cultural rules of both parties to become evident."* (Davis, 1998:331)

In the process, researchers learn about themselves as well as about others.

4.5 Qualitative data collection and analysis

4.5.1 Semi-structured interviews

Interviewing in qualitative inquiry is a special form of conversation, and, as Patton (2002:407) notes, a "*highly personal and interpersonal"* activity which "*opens up what is inside people."* As this is a study about relationships, the research relationship in the context of semi-structured interviews is discussed in detail. The first part of this section briefly reviews various influences on in-depth interviewing, discusses reflexivity and sensitivity in the interview process and examines the context and complexities of in-depth interviewing as a qualitative research tool. Subsequent paragraphs describe the application of principles in the interview process and development of interview materials in this study.

4.5.2 The interview relationship

The interview is a ubiquitous form of enquiry and its versatility has made it one of the most widely used and popular data collection methods in qualitative research (Legard et al., 2003; Irvine, 2012; Atkinson and Silverman, 1997). The popularity of the in-depth interview as a method belies its complexity, however, and it would be a mistake to think that because interviewing is simply a form of conversation it is straightforward

(Ribbens, 1989; Westcott and Littleton, 2005). Interviewing on sensitive topics requires a critical focus (Atkinson & Silverman, 1997), or "*critical edge*" (Thompson & Thompson, 2008:27) which questions assumptions, is reflexive and "*socially-located*" (Oakley, 1998: 715), and calls for awareness of the impact of power in relationships and attention to process, historical and socio-political context, and purpose (Fontana & Frey, 2008). Trotter (1998) addresses the mixed blessings of the influence of social work practice on social work research and, noting the importance of professional judgment, argues:

> *"...that researchers who work 'with and alongside' practitioners and clients, rather than work as distant experts, will produce results which are much more relevant and much more usable."* (Trotter, 1998:5)

Social work practitioners are accustomed to working in partnership with attention to context, which, in line with interpretative, feminist and social constructionist research approaches, promotes a shift in power from the interviewer to the interviewed person, placing the greater value on the contribution of the person providing the information than on interviewer expertise (Burr, 2003). In this view, interviews represent conversations with a common purpose of exploring a negotiated topic, a 'journey' (Kvale, 1996) in which there is capacity for researcher and researched to request and divulge information and potential for both to achieve new understanding and change.

The relationship between researcher and participants is not genuinely reciprocal, but power imbalance is mediated by respect, empathy, and a desire to learn and report something that will be of benefit to the person and society. The approach in this study addresses a responsibility compatible with Kvale's view of interviewing as a "moral enterprise" (Kvale, 1996: 109) serving both *"scientific and human interests*" (Kvale, 1996:110). Fontana's and Frey's (2008:117) "empathetic interviewing" similarly acknowledges that interviewing in the social sciences is politically and culturally informed and involves a duty to respect participants, and to interpret and report research findings and influence policy for the benefit of vulnerable groups.

Maintaining clarity about relational boundaries and power dimensions in research is important, because to do otherwise risks increasing participants' vulnerability (Ribbens, 1989) and altering the knowledge-constructing nature of the interview itself. There is a skill in balancing what Ribbens (1989:587) describes as "*elements of power and of empathy*". Ribbens illuminates the paradox of forming a relationship which ostensibly gives power to the interviewee only to have the interviewer retain control of the majority of the analysis, interpretation, and capacity to "*define another's reality"* which follows (Ribbens, 1989:587). From a research perspective, Ribbens' analysis of relationship offers an uncomfortable sense of disingenuousness in providing research participants with the opportunity to be experts in their own lives only to take control of their accounts. Avoiding such inconsistency in this study meant carrying a reflexive and empathic approach beyond interviewing into data analysis.

4.5.3 Sensitivity in interviewing

Interviewing sensitivity in this study recognises the interviewer's relative position of power, and therefore greater potential in the research relationship to warrant voice than participants (Burr, 2003). This interpretation of "sensitivity" differs from that presented by Corbin and Strass (2008:33) for whom the term represents focus on the researcher's capacity to avoid being distracted by prior knowledge and expertise and to focus on participant contributions and conceptual meanings. Both perspectives privilege participant views and meanings, but whilst the grounded theory approach strives for objectivity by suppressing the researcher's knowledge and theoretical understandings, postmodernist and constructionist sensitivity acknowledges that researchers have biases, contribute to knowledge-production and influence the course of interviews. It is the researcher's responsibility to remain aware and sensitive to the voice of participants in the interview. The purpose of interviewing "*is to allow us to enter into the other person's perspective*", and the *"quality of the information obtained … is largely dependent on the interviewer*" (Patton, 2002:341). As this study

involved interviewing three different groups of participants, the remainder of this section discusses special considerations relevant to interviewing each group.

4.5.4 The Interviews

All interviews followed a phased approach including introduction, rapport building, conversation, invitation to say more or ask questions, and ending. Interviews were recorded and transcribed by the researcher, and notes were made immediately following each interview. Differences in interviewing related to the differences among the three groups and individuals, and are explored in the following subsections.

4.5.4.1 Children and young people

> *"It is somewhat paradoxical that within the new sociology of childhood many of those who call for the use of innovative or adapted research techniques with children, are also those who emphasize the competence of children. If children are competent social actors, why are special 'child-friendly' methods needed to communicate with them?"* (Punch, 2002:321)

We cannot know exactly what it is like being interviewed by ourselves. This study invited young people to consider questions about the abstract and complex concept of personal relationship which involved recalling events and thoughts about a unique relational experience from what may have been a difficult time in their lives. This is the point where the research agenda coincides with the therapeutic space which the young person occupies and holds. We cannot and do not want to enter that space, but for a short time we ask permission to find out about it.

Awareness of children's developmental trajectories is helpful in planning and talking to young participants, but considerations in interviewing go beyond this. Young people in this study were viewed as active contributors rather than "*passive responders*" (Westcott and Littleton, 2005:143). Following Westcott's and Littleton's (2005) advice and keeping in mind that children's experiences of abuse could impact on the interview relationship, I avoided

defining young people by the status of “abused child” and focused on providing explanations about the research, boundaries, importance of each person’s view, and their expertise on what their therapeutic relationships were like.

I was prepared for each interview to be unique. The way children and young people think about themselves and respond to the world around them depends on the dominant cultural discourses they experience as they grow (Greene and Hill, 2005:5). This perspective on the development of self and identity suggests that all interactions and experiences are affected by context and previous interactions and experiences. In the context of a research interview – a new experience for all young people in this study – their sense of self and identity contributes to their understanding of the process and the questions and to the potential relationship with the interviewer.

Topic guides were developed for young people and children *(Appendix F).* Questions were open to facilitate free-flowing narratives, and the first question in each interview invited young people to tell me about their worker. Prompts (e.g. “What was it like spending time with your worker?”) and activity sheets were available, although the latter were intended to facilitate and complement the interview only if required, not to direct it. Problems I anticipated were phrasing open questions to enable children to demonstrate their thinking and competence, using appropriate language to avoid misunderstandings, making interviews interesting and enjoyable, and gaining trust with children who have had both positive and abusive experiences with adults.

4.5.4.2 Parents/‘Safe Carers’ and Practitioners

The paragraphs describing interviews with children noted the issues created when adults interpret children’s voices through their own eyes. Power dynamics in research conversations between adults are different from those in conversations with children. Parents whose children have been abused

may be vulnerable as research participants because impacts of child sexual abuse extend to family members and significant others (Kilroy et al, 2014). I shared some common status with parents (gender and/or parenthood) but our experiences of being judged as parents, particularly as mothers, was different, so in a sense what might have been an equalising status was in fact disempowering for parents. In addition, my status as a social worker potentially influenced parents' perceptions of my expertise, beliefs and values. Interviews therefore produced co-constructed accounts in the context of potential "*high risk*" (Croghan and Miell, 1998) for parents expressing their views. I was aware also that, just as I anticipated young people would talk about activities and conversations that happened during and outside their therapeutic sessions, parents were likely to talk about potentially upsetting matters related to the intervention. Topic guides for parents and carers invited them to consider more than one relationship experienced during the intervention because they had a relationship of some kind with their own and their child's worker, and they had views on the relationship between their child and her worker. Part of the researcher task included ensuring that participants were able to talk about each of these relationships whilst limiting expense and inconvenience.

Practitioners are not invulnerable to being affected by discussions about the relationships developed with children with whom they spent considerable time, and issues of power also existed in relation to their interviews. Topic guides were developed along the same lines as those designed for children/young people's interviews, but with consideration given to the points made above. The first question was open, as it was with children, but there was an expectation that practitioners would have different understanding of the concepts of 'relationship' and 'therapy'. Because practitioners knew of my social work background, I was prepared for interviews featuring more professional language, a different perspective and a different kind of researcher-participant relationship.

4.5.5 Qualitative data analysis

This section explains the rationale and underlying theory and principles of thematic analysis as applied in this study. It describes the use of the Framework approach (Ritchie and Lewis, 2003) to analysing data, using Nvivo QSR (version 10) software.

Framework analysis follows interpretive inductive and abductive methods, using techniques of coding and categorising, or “indexing” to use Framework terminology, which ‘ground’ the findings in the data. Thematic analysis is common to many qualitative enquiries using interpretative methods (Brymon, 2012) and the term is used to describe various approaches which may differ in method but share the development of themes derived from data. Thematic analysis was selected over grounded theory because, where grounded theory sets out to develop or generate theory (Corbin and Strauss, 2008; Willig, 2001), this thesis accepts for the purpose of this research, an established concept of the therapeutic relationship.

4.5.5.1 The process of data analysis

As the research process is iterative, it is understood that processes overlap, and that data collection, coding, and thematic development does not occur in tidy compartmentalised phases, but rather progresses towards a conclusion, in a non-linear fashion (Spencer et al., 2003; Bryman, 2004). This framework accepts that information gained early in the data collection process influences subsequent data collection and that such developments are acknowledged and form part of the analysis. Referring back to the original transcripts and notes was therefore part of the analytic process.

Interviews comprised dialogues looking back at relationships. This perspective differs from looking at current relationships – it involves retrospection, retrieval and selection of cognitive and emotional memories, and communication and interpretation through language. The research dialogues thus constituted brief relationships – shared experiences focused on co-constructing meaning about relationships. Active participant

involvement in the research ended when the interviews were finished, leaving the researcher with the responsibility to represent the perspectives offered as accurately as possible within the limitations of language and understanding.

4.5.5.2 Principles of coding and categorising data

The aim of coding data is to clarify and reveal rather than complicate and obscure (Saldaña, 2013). Initial coding of data is often an individual and solitary process and there are many ways of accomplishing it. Construction of categories and codes inevitably reflect the researcher's own interpretations and interests, and discussions in supervision were important to maintain focus and strive for clarity. Collaboration helps ensure that analysis is grounded in the data and responsive to research questions, and reflexivity helps avoid problems of data overload, misinterpretation, or misrepresentation of participant perspectives.

Sunstein and Cheseri-Strater (2007) provide a list of questions for qualitative researchers about what "*surprised", "intrigued"* and *"disturbed"* them throughout the coding process in order to track "*assumptions*", "*positionality*" and "*tensions within [the researcher's] value, attitude, and belief systems"* (Sunstein and Cheseri-Strater, 2007:106; cited in Saldaña, 2013:22). Saldaña in addition encourages qualitative researchers to be mindful of the "*personal attributes"* which ensure that their coding and the analysis and conclusions which follow are thoughtful, robust and systematic. These attributes include the capacity to be "*rigorously ethical"* (Saldaña, 2013:36-37), an attribute which is particularly relevant in studies with vulnerable participants, on sensitive topics, and with the potential to impact areas of policy and practice.

Coding and development of themes were guided by focus of the research questions on:

- Perceptions and meaning of the relationships
- Process (how did relationships develop)

- The evidence of “bond” (an affective connection between worker and young person or parent), collaboration on “tasks” (how people worked together), and agreement on goals (Bordin (1979)
- The reported characteristics and qualities of participants in the relationships developed during the intervention, and
- Perceived change in participants’ lives.

4.5.5.3 Reflexivity and filtering in the coding process

Discussion of reflection in analysis resonates with O’Connor (2007) who describes the reflective process as “*refraction”*. O’Connor refers to the “*mirrored reality and the researcher’s lens”* as*:*

> *“...dimpled and broken, obscured in places, operating as a concave or at other times convex lens. As such, it throws unexpected and distorted images back. It does not imitate what looks into the mirror but deliberately highlights some things and obscures others. It is deliciously ... unpredictable in terms of what might be revealed and what might remain hidden.”* (O’Connor, 2007:8; cited in Saldaña, 2013:50)

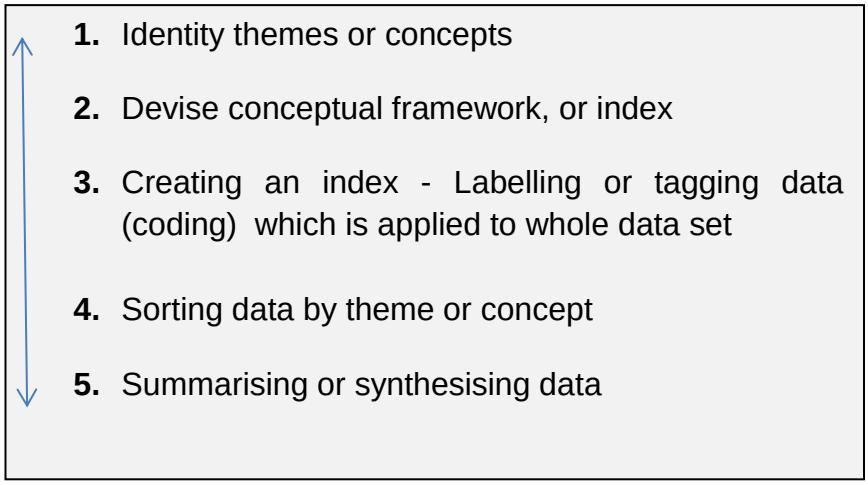
As this passage suggests, analysis of qualitative data is both science and art. As science, it is inexact but can be practiced methodologically and systematically. At the same time, analysis is creative and interpretive. Sipe and Ghiso (2004:482-3, cited in Saldaña, 2013:8) propose that “*all coding is a judgment call … our subjectivities, our personalities, our predispositions, [and] our quirks”* affect the research at all stages. Multiple realities exist before researchers even begin to analyse what they have found. The researcher from this perspective does not “discover” knowledge, but “*authors*” it (Willig, 2001:121).

4.5.5.4 Using Framework to develop themes, sort and classify data

The principles and practices described above were applied to analysis using the Framework method. Framework provides a systematic method of organising and classifying qualitative data through the development of a *“thematic framework”* which facilitates examination of themes and concepts within and across cases (Ritchie et al., 2003). Similarities with coding and

categorising in other analytic approaches such as grounded theory are evident, but the Framework method begins by devising a conceptual framework based on thorough familiarity with the raw data and creating an index to demonstrate how the raw data fits with the conceptual framework. Raw data included interview transcripts, contact records, and contemporaneous notes recorded following interviews. The order of tasks is shown below in *Figure 8*. Although the tasks are presented as if they are distinct, the analysis process is iterative, phases overlap, and may be repeated as familiarity and development of themes increase over time.

Figure 8: Framework analysis tasks



The analytic process in this study began with becoming familiar with the raw data, identifying recurring initial themes or concepts and subthemes. Themes must be evidenced in the data, so the indexing process involved assigning the raw data to the themes and subthemes, and continually refining and sorting. Nvivo software (*QSR Nvivo 10*) was used for the coding and extracting of themes and memo-writing which comprise the initial coding activities. Data are often able to be assigned to more than one category and it is important not to lose their original context, and Nvivo is helpful in maintaining such connections. Nvivo is compatible with Framework and enables the creation of thematic matrices in which comparisons and connections within and between cases and groups can be explored. The ultimate aim of this systematic management of qualitative data is not only to

aid the researcher in the descriptive analysis and discussion of findings, but also to clarify the pathway from raw data to conclusions.

Participants provided an enormous amount of data in their accounts, resulting in an initial list of 76 primary or “parent” nodes in NVivo with over 200 “child” nodes – an unmanageable number which was reduced to 21 “parent nodes” following initial coding by organising, collapsing and combining nodes. It was not until several transcripts had been coded that organisation of data into a manageable number of categories was possible. Transcripts were read with the research questions in mind, whilst remaining open to unexpected findings. Initial codes included, for example, words which young people used to describe their workers. As young people’s transcripts were coded first, it became clear that they used a variety of words, so these were grouped under “characteristics of workers”. When parent and worker transcripts were coded, it was apparent that they also provided descriptions of worker characteristics, and it was necessary to subdivide the node to distinguish amongst characteristics described from the different perspectives. Hence the coding process was thorough, organic and time-consuming.

4.5.5.5 From initial reading to thematic concepts

There are potential pitfalls in all research phases, and analysis is no exception (Braun and Clarke, 2006). The analytic aim is for themes to develop from the data and for data to be analysed rather than just reported. The use of the framework helps the researcher to evidence analytic thinking with examples from the data, and to refrain from relying on assumptions or impressions. The framework makes use of the language and exact words of young people and adults. Where interpretation of meaning is offered, the interpretive process is explained, and where meaning is linked to theory, the thinking behind the link is clarified, thus ensuring that the analytic process adheres to the same standard of transparency as the data collection.

Thirty-seven of the initial nodes were *in vivo* codes (quotes from transcripts) which represented statements from participants which stood out because they appeared to clarify or represent meaning for an individual or because they were descriptive, unique and difficult to paraphrase without losing the original impact (e.g. "*dancing around the edge"*). *In vivo* coding represents "*a strategy for getting at the organic poetry inherent in a participant"* (Saldaña, 2013:92). Thus *in vivo* coding could be evocative, metaphorical, and representative of far more than a short phrase might suggest. One node which proved particularly useful was labelled '*direct speech*', into which were coded all instances where participants quoted themselves or others in their interviews, as if they were situated back in the relationship. Such instances were initially identified and stored because intuitively they seemed to have a distinctive, but not immediately obvious role in interviews. However, as the research conversations represented retrospective perspectives on relationships, it became apparent that '*direct speech*' passages had the capacity to bring the therapeutic relationship into the present. Participants spoke as if they were repeating conversations from another relationship – speaking directly to the other person, being spoken to, or expressing thoughts that they had at the time. These were constructed representations of an individual's contribution, and occasionally both sides of a dialogue at a particular point in time. It is a re-telling technique used in everyday exchanges to relate past events or conversations, and has the effect of bringing the past to life in the present. It resonates with the phrase "*lived experience"* which Parton and O'Byrne (2000:53) cite in explaining how we describe our lives in narratives offered in the present while referencing the past:

> "*Behaviour always happens at a point in time and by the time it is reported it is in the past, but the telling and the meaning we attach to it is still in the present. Interpreting an event therefore can be likened to <u>reading</u> a text and each interpretation or reading makes for a new text, a different writing"* (Parton and O'Byrne, 2000:53, emphasis in original)

"*Direct speech*" examples are used throughout the presentation of findings to illustrate points brought to life in this way by participants, and are underlined in each case to identify them.

4.6 Chapter Summary

This chapter described the methods of data collection and analysis, and the ethical considerations of undertaking research with vulnerable groups on sensitive topics. It focused on interviewing participants within groups described as vulnerable, pointing out that vulnerability as a social construction may ignore the resilience and strength of individuals. It discussed the concept of sensitive topics, referring to measures taken to monitor participants in interview for signs of distress, or alternatively signs of positive emotions. Finally, the chapter explained the use of framework analysis and NVivo as analytic tools. The following chapter introduces the participating teams and individuals in more detail.

5 Chapter 5: Introducing the participants

5.1 Introduction

This Chapter introduces the study participants and the Agency teams, or service centres, from which they came. The first section highlights issues related to referral of young people and their families to the study and considers explanations for difficulties. The second section offers portraits of the individual participants.

5.2 Participating teams

The three participating service centres were based in cities and situated within the same region of the United Kingdom. Centre A had the largest population and Centre C the smallest. Centre A correspondingly had the largest team and greatest number of full time equivalent practitioners delivering the intervention. For the year 2014–2015 Centre B had the highest number (and highest proportion for the population of children) of children on Child Protection Plans (CPP), but only approximately 2% of children on a CPP were included solely for risk of sexual abuse. As noted in Chapter 4 uptake of the invitation to participate was initially slow but ultimately Centre A provided four referrals, Centre B one referral, and Centre C three.

Explanations for the variation in referral rates to the study were considered. Centres B and C were smaller in team size and city population than Centre A and had a lower number of full-time equivalent staff working on the intervention. In addition, the intervention was relatively new and established referral routes may have altered or become inappropriate as criteria for service changed. Another possibility was that the gatekeeping procedure was being applied differently, or more rigorously particularly in Centre B. However, it may simply have been that referral numbers were low, and therefore it was a matter of chance that during the data collection phase there were fewer children completing the intervention.

In order to document reasons for low study referral rate, Centre B provided monthly reports on 14 cases which were closed during a six month period.

These reports indicated various reasons why young people were not given details of the study. The most often cited reason was that the case was closed at the referral assessment or assessment phase (nine cases out of 14) which meant that the case did not fit the study's criteria as it did not proceed to the therapeutic phase. The remaining five cases were closed at the intervention phase, one by the parents before the work was finished. Four children completed the intervention – in one case the parent/carer did not give permission for the child to participate in the study, and in the other three the team decided it would be inappropriate.

5.3 Participating service users

The research criteria for referral to the study were that the young person must have completed the intervention and the *TASC* at T2 if used, and be able to give informed consent to participate. In the eight families, a total of 24 interviews with 26 participants were conducted with six young people (all female), seven parents/carers (six female, one male), and 12 practitioners (10 female, two male). Two female practitioners were interviewed more than once in respect of different families – one was involved with two different cases, and one practitioner worked with three different young people. Hence, although there were 12 practitioner interviews, these involved seven individuals. Both the male workers provided a service to parents. All young people and their families were white British. Young people were given details of the study along with the letter inviting them to participate and to return a consent form agreeing for the researcher to contact them. The time elapsed between young peoples' completion of the intervention and interviews ranged from approximately eight weeks to 12 months, with all but one young person's interview taking place within 16 weeks of from the end of the intervention. Two interviews were joint interviews, one with a married couple and the other with a young person and her carer.

All interviews were arranged at a venue, date and time of the participants' choosing. Twenty-four of the twenty-six individuals had face-to-face interviews in the home, at the service centre, or in one case (practitioner) at

an alternative venue. Two interviews, one with a parent and one with a practitioner, took place over the telephone. *Table 1* provides details of participant numbers and interview venues.

Table 1: Interview participants

Participants	Number	Interview venue		
		Home	Centre	Telephone
Children and young people	6	5	1	-
Parents and carers	7	4	2	1
Practitioners – child	8	1	6	1
Practitioners – carer	5	-	5	-
Totals	26	10	14	2

5.3.1 Young people

Six young people were interviewed. The decision about whose contact details were provided was left to the family. I contacted parents first where possible in the interests of safeguarding young people, both to ensure that parents were aware that I would be contacting young people and to reassure them of my identity. In two cases, parents had neither received a service nor provided contact details so arrangements were made directly with young people, with parental knowledge. Interviews were all under an hour. In three cases some activity sheet prompts were used (e.g. *Word Tree,*) and one young person drew a picture of her worker, but in general interviews consisted mostly of conversation. The activity sheets were intended primarily to promote dialogue about the relationship, and in fact contributed little content to the overall accounts young people gave. One young person asked if she could go through a book of activities which she created during her sessions to help her remember about the time she spent with her worker.

5.3.2 Parents and Carers

Two parents (married couple, CASE 1) were interviewed together. One foster carer (CASE 4) was interviewed with the young person. The four remaining parents, all mothers, were interviewed individually. All parents/carers had been assessed prior to commencement of the intervention as "safe" carers. Interviews ranged in length from half an hour to an hour. With the exception of the foster carer, all interviewed parents were involved in the carer service. One parent (CASE 2, father) declined to take part; in the other cases where no parent was interviewed (CASES 6 and 8) parents did not have a service and were not interested in participating. Parents were asked about their relationships with their own workers, with their child's worker, and also for their perspectives on the relationships their daughters had with their workers.

5.3.3 Practitioners

All involved practitioners agreed to participate. Young people and parents were interviewed before their workers to ensure that I had explicit consent to talk to them. The exception was where young people had not wanted to take part but had agreed that their workers could be interviewed. Workers were not given information about what young people or parents said, both to preserve confidentiality and to avoid contaminating practitioner accounts. Dates, times and venues were arranged at workers' convenience. *Table 2* is an interview log showing participants in each young person's case.

Table 2: Interview Log

	NAME	INTERVIEW DATE	TEAM/CASE	PERPETRATOR*
1	Anya (16 years)	27/02/14	A/Case 1	*Peer*
2	Anya's Mother & Father	27/02/14	A/Case 1	
3	Anya's Worker	13/03/14	A/Case 1	
4	Anya's Parents' Worker	07/04/14	A/Case 1	
5	Brenda (17 years)	10/04/14	A/Case 2	*Known adult*
6	Brenda's Mother	10/04/14	A/Case 2	
7	Brenda's Worker	13/05/14	A/Case 2	
8	Brenda's Parents' Worker	22/04/14	A/Case 2	
9	Chelsey's Mother	03/06/14	A/Case 3**	*Extended family member*
10	Chelsey's Worker	01/07/14	A/Case 3	
11	Chelsey's Parents' Worker	04/07/14	A/Case 3	
12	Darcie (18 years) with her Foster Carer	09/07/14	A/Case 4	*Peer; triggered past trauma*
13	Darcie's Worker	23/07/14	A/Case 4	
14	Evelyn (11 years)	15/09/14	B/Case 5	*Extended family member*
15	Evelyn's Mother	04/09/14	B/Case 5	
16	Evelyn's Worker	19/09/14	B/Case 5	
17	Evelyn's Mother's Worker	27/10/14	B/Case 5	
18	Frances's Worker	10/10/14	C/Case 6**	*Peer abuse*
19	Georgia (16 years)	05/09/14	C/Case 7	*Step-father*
20	Georgia's Mother	03/10/14	C/Case 7	
21	Georgia's Worker	10/10/14	C/Case 7	
22	Georgia's Mother's Worker	07/10/14	C/Case 7	
23	Heather (aged 15)	19/09/14	C/Case 8	*Mother's partner*
24	Heather's Worker	10/10/14	C/Case 8	

**Limited details about the nature and perpetrator of the abuse were provided in the course of young people, parent, or worker interviews – no files were seen.*

*** Chelsey and Frances declined interviews.*

5.4 Snapshots: case descriptions and engagement with research

To provide an overview of the range of individual circumstances and engagement in the research of participants, snapshots of each young person and her participating parents/carer are provided below. Reflective analysis of the researcher-participant relationship and how it impacts on the research

conversation and meaning making is provided in the concluding chapter. All names are fictitious and some details deliberately vague to preserve confidentiality and anonymity.

5.4.1 Case 1

Anya

The young person in CASE 1 (YP1), *Anya*, was aged 16 at the time of interview, and was attending the local school. She was living with birth parents in their own home and was the youngest child in the family – siblings were no longer at home. Both parents worked. Anya was abused by a boy known to her at school, and did not disclose for several months. Eventually she told a professional outside the school who informed the police; subsequently parents and the local authority social worker arranged for her referral to the intervention. Both parents and Anya agreed readily to talk to me at their home. In preparation for the interview I liaised by telephone with both parents who arranged time and venue in discussion with Anya. Anya spoke positively about her worker and their relationship. Anya's individual *TASC* scores were not available.

Anya's mother and father

I had spoken with both parents on the phone before we met, so we had exchanged information and established some familiarity. The parents informed me before the interview that they were very happy with the service and grateful for the help they received. They were unhappy, however, with the way the school had managed the situation, and used their own sessions in part to explore this issue. Anya's parents saw their worker between six and eight times together and her mother had one session alone. Each described their worker similarly, but talked about the relationship in terms which represented how individually they made different use of the time they had with her, so developed slightly different relationships with the same worker. Anya's parents described a positive relationship with Anya's worker

and their own worker, and found her reassuring and helpful for emotional and practical support.

5.4.2 Case 2

Brenda

The young person in CASE 2 (YP2), *Brenda,* was aged 17 at the time of interview, was working, and was interviewed at home. She was living with her birth parents and two siblings in their own home. Both her parents worked as professionals. Brenda's abuse was perpetrated by an adult living locally and she was referred to the intervention following involvement with a sexual exploitation unit. The family had experienced disruption, distress and displacement in the aftermath of Brenda's disclosure. This was a family who, following disclosure, supported Brenda and maintained privacy but shared as appropriate within the family information about what had happened or about the intervention. Each family member had received or was currently receiving support because of the impacts experienced. In preparation for interview, I liaised with both Brenda and her mother. We all agreed that in order to minimise intrusion on the family's time, I would interview her mother first. When I spoke with Brenda, she described a positive relationship with her worker which developed gradually and was ultimately hugely significant for her. Brenda's individual *TASC* scores were not available.

Brenda's mother and father

I liaised with Brenda's mother by telephone, but only met her father briefly when I visited. He was at home though not interviewed. Brenda's mother was satisfied with their service and positive about Brenda's relationship with her worker, but unhappy and distrustful of many professionals from other agencies with whom they had been involved. Although Brenda's sessions had ended approximately four months previously, her parents were still experiencing emotional and practical impacts of events. Brenda's mother was a professional with knowledge of therapeutic services, which she felt

coloured the couple's expectations and experience of the relationship with their worker. She also had a professional understanding of therapeutic relationships. Brenda's mother described the relationships the couple had with Brenda's worker and their own worker as positive.

5.4.3 Case 3

Chelsey

The young person in CASE 3 (YP3), Chelsey, was aged 10 at the time of referral to the study. Chelsey and her mother talked about whether she wished to participate in an interview; she did not, and her mother supported her wishes as she was concerned that Chelsey now wanted to leave the entire experience behind her. Chelsey had been abused by a member of the extended family who had consistently denied that the abuse had taken place. Although declining to take part, Chelsey agreed that I could speak to her parents and her worker. Chesley's mother confirmed that Chelsey's relationship with her worker was very good. In preparing for interview, I liaised only with Chelsey's mother. Chelsey's individual *TASC* scores were high at both T1 and T2 (high scores described here as a sum of individual item scores being between 36 and 48, where 48 is the maximum) and had gone up at T2. Her worker's scores were also high at T1 and T2.

Chelsey's mother

Chelsey's mother required both reassurance about confidentiality and also confirmation of my identity and status in the Evaluation. She was entirely satisfied with the service the family received, but remained anxious about meeting me and chose as a venue the service centre rather than disclose her home address. For her, emotions were close to the surface, and she became upset at the beginning of the interview yet chose to continue. She had found accepting and understanding what had happened, given that she knew and trusted the perpetrator, particularly difficult, and the impacts on relationships in the extended family devastating. She described her relationship with Chelsey's and her worker as positive. Chelsey's father had

been briefly involved in parent sessions at the beginning, but had stopped attending.

5.4.4 Case 4

Darcie

The young person in CASE 4 (YP4), Darcie, was aged 18 at the time of interview. She attended with her foster carer with whom she had lived for some time and whom she sometimes referred to by name and sometimes as her mother. Darcie and her carer both confirmed that Darcie's learning difficulty did not prevent her from understanding the nature and purpose of the interview and she was able to give informed consent. She occasionally struggled with some questions which were too open, complex or poorly worded and on these occasions her carer was able to support her. There were no details of Darcie's sexual abuse experience except that a recent experience re-triggered trauma from a past experience. My initial communication by phone and email was with Darcie's carer but Darcie telephoned me a few days before the scheduled interview to say hello and tell me that she had been missing her worker. Darcie described her relationship with her worker as positive, a view which her carer confirmed. Darcie's individual *TASC* scores were high at T1 and T2 with little change, as were her worker's scores.

Darcie's carer

Darcie's carer did not have a parent service, as she had an existing professional support network. However, she contributed her perspective in the joint interview on Darcie and her worker's relationship.

5.4.5 Case 5

Evelyn

The young person in CASE 5 (YP5), Evelyn, was aged 11 at the time of interview. Evelyn was abused by an extended family member when she was

very young. She disclosed to her mother a few months later, at which time her mother felt she was too young for formal support and seemed to be coping well. Evelyn's mother, on the other hand, was deeply affected by the disclosure and found it disrupted family relationships and changed their lives. It was Evelyn's request for help which prompted the referral to the agency. We agreed that I would interview Evelyn's mother first to provide reassurance and confidence in both researcher and process. Given that her therapy had ended a year before, Evelyn demonstrated good recall, confirmed by her mother, and was able to describe details of activities and techniques she said helped her. She was understandably wary when I first arrived, but generally cheerful, articulate and communicative. Evelyn described her worker in positive terms. Evelyn's individual *TASC* score was high at T1; no score was recorded at T2. Her worker's scores were high both times.

Evelyn's mother

Evelyn's mother was demonstrably affected by the changes that came about for her and her daughter during and after the intervention. She was open and warm, and despite the time that had gone by since the intervention finished, talked in detail about her own emotional turmoil and the significance of the changes in her and her daughter following the intervention. Evelyn's mother was positive about her relationship with her worker and with Evelyn's. Like other parents, she had a perspective on Evelyn's and her worker's relationship, seeing it as positive.

5.4.6 Case 6

Frances

The young person in CASE 6 (YP6), Frances, aged 15, gave consent for researcher contact, but was not interviewed. Frances and I were in contact for a number of weeks by text, letter, phone and email. Our communication included a short video in which I introduced myself and the study. Frances

expressed interest and we arranged two interview dates which were both cancelled. I had a strong sense of ambivalence in her about meeting, and in our last telephone conversation I suggested that arranging an interview seemed complicated but that if she chose to tell me about her relationship with her worker in another way – using the young person's activity sheets or writing for example – she was welcome to do so and I would include her contribution. I did not hear any more from her. As her parents were not involved in the intervention, the only interview in Frances's case was with her worker. Frances's individual *TASC* scores were high at T1 and T2, and her score had gone up at T2. Her worker's score was low at T1, but high at T2.

5.4.7 Case 7

Georgia

The young person in CASE 7 (YP7), Georgia, was 16 at the time of interview. *Georgia* was abused by an extended family member with whom she was living, and following her disclosure returned to live with her mother. I liaised with Georgia to arrange a convenient interview time at her home and in a reverse of the more common practice I was eventually able to contact her mother with Georgia's help. Both Georgia and her mother praised their workers and the intervention, and described positive relationships with their individual practitioners. Georgia was outwardly confident, welcoming, appeared at ease, and understood the focus of the research, although there were deviations into unrelated areas which may have indicated that the topic was boring or uncomfortable at times, that her attention was wandering or that other aspects of her life were just more interesting. Georgia particularly wanted to talk about what she is doing now, how much she had changed over the past two or three years, and how much her worker had helped her. Her interview was characterised by examples of things that her worker did for her and with her, and comparisons of her life now and her life before. Georgia's individual *TASC* score was high at T1 as was her worker's; no scores were recorded at T2.

Georgia's mother

I interviewed Georgia's mother by telephone. She was willing to participate but as a professional working in social care had an extremely busy and sometimes unpredictable schedule. Georgia's mother described first Georgia's relationship and work with her worker before talking about her own sessions. Telephone interviews tend to be more difficult than face-to-face interviews because visual stimuli and information are missing. Nevertheless, she gave a full and detailed account of both relationships with more content related to context and background than in other cases. Georgia's mother had professional expectations and understanding of what might be involved in therapy and the therapeutic relationship, and in terms of her own sessions, professional awareness and knowledge of child sexual abuse. She had a positive working relationship with her daughter's worker as with her own, and saw them as serving different purposes for her.

5.4.8 Case 8

Heather

The young person in CASE 8 (YP8), Heather, was 15 at the time of interview. Heather was abused by an extended family member and subsequently moved to live with her father and his partner, neither of whom was involved in the intervention. Heather was eager to take part and described a positive relationship with her worker. Unusually, she was referred for intervention twice – the first time by other professional services, and the second time as a self-referral in which she requested the same worker she had before. I liaised entirely with Heather to arrange the interview. She was welcoming and friendly, and immediately told me about school, her friends, and some details about family dynamics and circumstances. Heather was the only young person who asked if she could mention what happened to her because it would help her talk about her relationship with her worker, and because she wanted to talk about an

activity book that she completed during the intervention. She described a positive relationship with her worker. Heather's individual *TASC* scores were high at T1 and T2, and her scores at T2 had gone up slightly. Her worker's scores showed the same pattern.

5.5 Chapter Summary

This brief chapter has introduced the participating teams and individuals. The number of participants was not as great as hoped, and all the young people are White British and female. Boys are only represented in the TASC sample, therefore. Whilst this in no way affects the value of qualitative data or the contributions of all who participated, it is important to note the gender imbalance in reporting on the findings.

The following four chapters present the findings, beginning with presentation and discussion on development of the relationship in therapy in the context of creating a safe relational space.

6 Chapter 6: Constructing a safe relational space

> *"…just as trauma can lead to isolation, connection can heal."* (Goelitz & Stewart-Kahn, 2013:22)

6.1 Introduction

Presentation and discussion of findings begins with young people's and parents' initial experiences of building relationships with their workers. Horvath (2011a), in his meta-analysis of therapeutic practices, makes two important statements: he points out that the *"development of a 'good enough' alliance early in therapy is vital for therapy success",* and that therapists do not 'build' alliance – they create the circumstances in which alliance develops or emerges (Horvath et al., 2011a:56). Where Horvath distinguishes the 'alliance' from the therapeutic relationship, this study looks at the relationship in its entirety. The vision of therapy as providing a safe space to heal is common and not bound by client age or circumstances or by therapist orientation. Horvath views the therapeutic relationship as interconnected qualities including the creation of a "*safe secure environment"* (Horvath, 2011a:56); Scott-Nash (2002:124) describes the therapeutic process as therapist and child having "*co-constructed a space and a relationship that formed a safe and healing place where together we explored themes of recovery and resolution."* It is how those engaged in the intervention perceive the process of developing and working in a safe, relational space for healing that is of interest in this study.

This chapter responds to research questions 1, 2, 3, 4 and 5, examining the development of therapeutic spaces, the growth of relationships, and the characteristics and processes identified as important by young people, their carers, and practitioners, particularly at the start of the intervention as they get to know each other:

- Question 1 invites participants to consider to what extent positive relationships are established in the intervention. The quantitative sample complements interview data by providing some measurement of strength of young people's relationships with their workers.

- The quantitative sample also addresses Question 2 and 3. The scores on the TASC items related to bond provide one way of describing how bonds are evidenced and relationships change. The interview conversations add rich detail about relational process.
- Question 4 asks what characteristics are associated with establishing relationships; this chapter draws on participant descriptions of what they perceived as helpful in building relationships.
- Research question 5 asks what patterns, or similarities, are found amongst individuals or among the three participant groups in their accounts of developing therapeutic relationships.

The first section describes and discusses the results of the TASC analysis comparing the findings of the sub-sample with the Evaluation findings. The remainder of the chapter presents findings from the qualitative data. The chapter is divided by group, starting with young people's and their practitioners' accounts, and followed by parents' and their practitioners' accounts. Within each group commonalities and individual differences are pointed out, and as the chapter unfolds similarities and differences across groups are discussed. The chapter concludes with a summary and discussion of the main points.

6.2 Quantitative sample: Examination of TASC scores

This section presents data from the sample of responses on the *Therapeutic Alliance Scales for Children* (*TASC;* Shirk and Saiz, 1992). It describes results of the analysis of the young people's (youth) and practitioners' (worker) scores the first (T1) and second (T2) time of completing the scales. The composition of the TASC is described in Chapter 4 (Section 4.2.1) along with the sampling method (Section 4.2.1.1). The Evaluation findings on strength of the alliance amongst youth are noted and compared with sub-sample examined in this study. I analysed the data using IBM SPSS (*Version 20)* and in this chapter focus particularly on six items of the bond scale of the TASC as relevant to the building and maintenance of a safe relationship in therapy.

6.2.1 Sample description

The “study sample” (N=148) refers to the subset of children whose TASC scores along with practitioner scores were analysed in this study; the “evaluation total sample” (N=242) refers to children in both the Intervention group and the Waiting List group regardless of whether they completed the TASC. This study, in order to describe strength of relationship and change between the first and second scores, used as matched pairs the T1 and T2 scores for each child completing the TASC twice, regardless of whether their own practitioner did the same, and as a different set of matched pairs the T1 and T2 scores for practitioners. The median was used as a measurement as the sample was not normally distributed and the units were categorical. In addition, I analysed changes in scores on individual items, a focus not included in the evaluation report. The evaluation analysis of TASC responses also involved a subset of child and practitioner TASC scores, but examined only matched pairs of children with their own practitioners who both completed the TASC at T1 and at T2 (Carpenter et al., 2016:64). It is likely that the two subsets overlap and some TASC responses are represented in both the evaluation analysis and this analysis, but it is not possible to describe how many or which ones.

Some information was available in the evaluation report (Carpenter et al, 2016) to enable comparison of the evaluation total sample with the study sample. Three-quarters of the study sample (n=111) were aged 8 years and over, compared to two-thirds (n=162) of children aged 8 years and above in the evaluation total sample. Of the 148 young people included in the study sample, 75 percent were girls (n=109, 3 cases missing), the same proportion found in the evaluation total sample. The age of the study sample ranged from 4.5 years to 17.8 years. The mean age is 11.5 years (SD = 3.79) at T1, slightly higher than the mean of 10.7 years reported in the evaluation sample. The guidance for completing the TASC is age 7 years and above (Shirk and Saiz, 1992), but some younger children completed scales. The discussion below refers only to children aged 7 and above (n=126).

6.2.2 TASC: youth and worker scores related to children aged 7 years and above

Similar to the evaluation, fewer young people in the study sample completed the TASC at T2 (n=76) than at T1 (n=130). Corresponding numbers in the worker group are T1 (n=136) and T2 (n=90), and more workers than children completed the scales both times. Total scores in practitioner and child groups were not normally distributed. Analysis of the direction and extent of change includes only those children and workers who provided scores both times. Scoring was on a scale ranging from low (1 = not like me/child) to high (4 = very much like me/child) on both scales. Children who completed the scale at both T1 and T2 (n=66) were very positive about relationships with workers. The highest possible total score was 48; the minimum 12. Median total scores for those children who completed scales both times were: T1 40.75 (IQR = 37.0 – 43.0) and T2 44.0 (IQR = 41.0 – 47.0). A Wilcoxon Signed-rank test showed a statistically significant median increase in total TASC scores for young people aged 7 years and over between T1 and T2 ($Z = 5.304$) $p < .0005$. This represents a medium effect ($r = 0.45$).

Practitioners who completed the scale at T1 and T2 (n=72) were also very positive. Median total scores for those practitioners who completed scales both times were: T1 37.5 (IQR = 33.25 – 40.0) and T2 39.0 (IQR = 35.0 – 42.0). A Wilcoxon signed-rank test determined that there was a statistically significant median increase in total TASC scores for practitioners between T1 and T2 ($Z = 3.799$) $p = .001$. This represents a small effect ($r = 0.27$).

As this chapter is concerned primarily with how workers and young people perceived the creation of an affective bond, the scale items related to bond are examined below. Items related to tasks, or working together on problems, are discussed in Chapter 7.

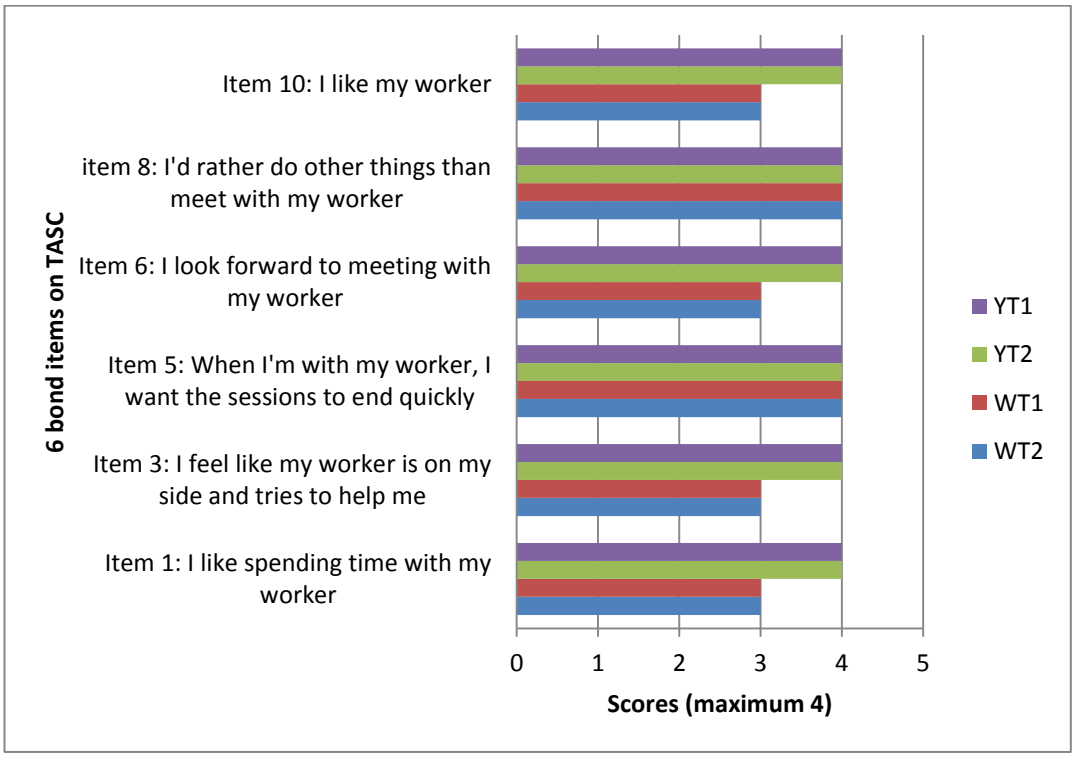
6.2.2.1 Bond items

Six bond items are analysed in this section. The maximum score was 24, minimum 6. Median total bond scores for children (n = 66) who completed

the scales both times were: T1 23.5 (IQR = 21.0 – 24.0) and T2 23.0 (IQR = 21.0 – 24.0). A Wilcoxon Signed-rank test determined that there was no statistically significant median change in total bond scores for young people aged 7 years and over between T1 and T2 (Z = -0.485) p >.05. Median total bond scores for practitioners (n = 72) who completed the scales both times were: T1 20.0 (IQR = 18.0 – 22.0) and T2 21.0 (IQR = 19.0 – 23.0). A Wilcoxon Signed-rank test determined that there was a significant median increase in total bond scores for practitioners between T1 and T2 (Z = 2.962) p =.003. This indicates a small effect (r = 0.24).

Looking at each question reveals more about the sample. Matched pairs (those who completed the scales both times) were selected to analyse each individual question to examine change between T1 and T2. The results are shown in *Figure 9.* With the exception of items 8 and 5, the medians of young people's scores (n = 67) were a point higher than worker scores (n = 72). The graph demonstrates visually the similar positive ratings of relationships in both groups. For analysis, items 5 and 8 are reverse scored.

Figure 9: Median bond scores, youth and workers T1 and T2



To see if any of the changes were significant, each question was analysed using Wilcoxon Signed-rank test. In the youth group, between two-thirds and three-quarters of young people gave the same scores at T2 as at T1 for each item. In those cases where scores changed the differences were not significant. On item 6, "*I look forward to meeting with my worker*", more scores (14) went down than up, indicating a small but significant median decrease in rating (Z = -2.132), p = .033 (r = -0.18).

In the worker group, two questions revealed changes reaching a level of significance but again effect sizes were very small. On items 1 and 3 for example, while most scores remained the same, at least twice as many workers changed their scores in a positive direction between T1 and T2. A Wilcoxon Signed-rank test on item 1 determined that there was a significant median increase in the scores for practitioners between T1 and T2 (Z = 1.964) p =.005, indicating a small effect (r = 0.16). The same test for item 3 determined that there was a significant median increase in the scores for practitioners between T1 and T2 (Z = 2.245) p =.025, again a small effect (r = 0.18).

6.2.3 Discussion

TASC scores overall confirm positive ratings of therapeutic alliance, a significant positive shift in scores in the youth group, and strength and consistency in scores on bond items particularly in the youth group. The evaluation report (Carpenter et al., 2016:66) similarly reported "*a consistently positive picture of the therapeutic alliance from both sides."* The Wilcoxon Signed-rank test suggests that for young people median total scores on bond items did not change significantly between T1 and T2, and effect sizes were very small. However, Wilcoxon Signed-rank test statistics indicate that 39 percent of the scores remained the same and, of the rest, approximately half went up at T2 and half went down. This is a more complicated picture than the no effect result suggests. The same subtleties may be found in the

practitioner group, where results suggest that bond scores shifted negatively or positively more often than in the youth group.

The individual item examinations are interesting. For example, on item 6, in both groups, most individuals scored the item the same both times (youth group – 71 percent; worker group – 66 percent). Yet, more scores went down at T2 than went up in the youth group. T2 scores were collected at a point where young people had met with their workers several more times. It is possible that young people might have been thinking about finishing and moving on, or they might have been at the phase of therapy where they were addressing difficult problems. Possibly, regardless of how much they liked their workers in general, at that point meeting with workers represented something less positive than it had at other points. The score changes for workers on item 6 represented a small but positive upward trend. In the worker group, item 3 (*"the child considers you to be an ally"*) indicated greater movement in scores than on other items, with only 50 percent of practitioners giving the same score each time, and 66 percent of those who changed their scores scoring higher at T2 than at T1. At T1 and T2, nearly all children scored this item a 3 or a 4 compared with 75 percent of workers who scored it 3 or 4 at T1. Possibly workers – as adults and professionals – are more circumspect than children about what being an "ally" means and were hesitant in early stages to interpret children's actions or words as signalling that they felt workers were on their side. Over the following 6 months they may have gained confidence in children's perception of workers as allies.

6.2.4 Summary

The TASC provide one way of obtaining participant perspectives on therapeutic relationships. Examining details of score changes reveals overall consistency of positive therapeutic alliance in the study sample and moderate change in scores both up and down the scale. The bond items analysis indicates that for the most part children in their sessions like spending time with their workers, consider them to be allies, are willing to

come and prepared to stay for the duration of sessions, and express positive emotion toward workers. However, the scale is not sensitive enough to detect subtle changes in relationships, and the six-month scoring interval does not offer insight into how relationships develop or decay. Further, scoring on scales is subjective and open to influence by external circumstances at the time of completion. This does not minimise the usefulness of the scales as a broad measure, but suggests that they are limited in their capacity to explain how relational shifts occur. This raises important questions: for example, what might be associated with the movement in scores related to whether the child sees the worker as an ally? How do workers and children develop relationships, what are the barriers and aids, what is important to individuals in each group? These are questions better answered using qualitative methods that explore participants' accounts of establishing relationships in the context of therapy.

6.3 Young people's views: creating a safe space

Young people's qualitative accounts are grouped in four main themes of safety, trust, confidentiality and privacy (*Figure 10).* Although presented separately, these are interconnected relational experiences, which together contributed to the formation of a safe and secure space.

Figure 10: Young people - creating a safe space

Young People – creating safe spaces	
Theme	**Subcategory**
Safety	• Dispelling anxiety • Familiarity, comfort, calmness • Worker characteristics (friendly, warm)
Trust	• Reassurance • Connection – "*I liked her"* • Believing • Not questioning
Confidentiality	• Relational space • Confidentiality limits
Privacy	• Physical space • Not shared with others • "Be Myself"

6.3.1 Safety

The process of developing relational safety started with young people beginning to feel less apprehensive about meeting a new person and engaging with an unknown process. Each of the six young people expressed feelings of worry or anxiety when they first met their workers using words such as "*anxious*" (Anya); "*intimidated*" (Brenda); "*nervous*" (Brenda); "*scared*" (Evelyn). Looking back on her experience, Darcie said that her first meeting with her worker was not as scary as she had expected, although she felt uncertain:

> *"...I wasn't too sure when she came to the um, our house, even though the first, that time that yeh I was like 'Yeh, let me try this'[1] you know but then just ...I got more comfortable."* [Darcie, 340-343]

Heather said that she felt it was "*hard*" to talk with her worker at first, she did not think that she would "*like her",* but when she returned following her second (self-) referral she felt she "*got to know her*" and her experience was different. The anxieties expressed by young people were related both to not knowing the person they would be meeting, and not knowing what "therapy" was. Their expectations ranged from a fear that they would be asked a lot of questions (Anya and Brenda) to thinking that therapy was "*kind of someone looking into your head and stuff"* [Brenda, 50-51]. At the same time, as Brenda's reference to being *"open to it as well, and interested to see what she was like"* [Brenda, 31-32] illustrates, young people were not entirely negative about trying something new. Young people described feeling safe, reassured, confident, understood and cared for after overcoming their initial nervousness. Darcie recalled, when asked for her first impressions of her worker, how her feelings changed to feeling comfortable:

> *"I really liked her, like the first impression was, I felt really comfortable, and that I can actually trust her, you know, with loads of things. Yeh, and then when we start, you know, I said to her I was a little nervous, like I didn't know how I liked it yet, it was like this place was new for me."* [Darcie, 33-36]

Developing a sense of safety began with the first meeting and continued through the first phase of the intervention as young people and their workers became acquainted. Young people variously described feeling "*relaxed"* and *"comfortable*" (Anya; Darcie); "*like another home really*" (Darcie); *"calm*" (Anya); "*like I knew her already*" (Evelyn); "*understood*" (Brenda); *"safe*" (Heather). They offered descriptions of what workers did, or how they behaved which contributed to the positive feelings about the space being

[1] "Direct speech" passages in interview extracts are indicated by dotted underline.

created. Common words and phrases, which related to how workers presented themselves and behaved towards young people as the relationship developed, included: "*nice*", "*friendly*", *"warm*", "*funny*", "*calm"* and "*relaxed*" suggesting a positive, friendly calm environment. A sense of calmness was indicated by young people saying that their workers spoke in a "*calm voice*", that they were "*quiet*", "*patient*", "*friendly*". Feeling comfortable in the physical space and with the other person was important for young people who reported that they were relieved not to be asked a lot of questions and not to feel rushed or pressured. Young people appreciated feeling that there was a routine to their sessions, including having the same room. Workers behaved toward young people with "*respect*" (Brenda, Georgia and Heather) for their feelings and their wishes, which contributed to a sense of being cared for and valued. Young people appreciated feeling that their workers believed them and listened. It was important from the beginning that their fears of being questioned and made to talk about their abuse, in contrast to encounters with other professionals such as police, were not realised. Young people described feeling a sense of familiarity with workers which engendered a sense of safety: "*she was like my friend",* [Evelyn, 345]; "*almost like a family, a person in your family"* [Anya, 309].

6.3.2 Trust

Developing trust was interlinked with feeling safe. Brenda said that when she first met her worker she struggled to trust anyone, including professionals. She was at a difficult point in her life, where a number of different people and agencies were involved, each with a different agenda, and adding another could have magnified her feelings of suspicion and mistrust rather than offering resolution. Although it took of time, she considered her worker to be different:

> *"...it didn't take me long to trust her, and while's it was quite, cus at the time I didn't really, I wasn't very trustworthy to many people."* [Brenda, 23-24]

This statement was one of the first she made when invited to describe how she got on with her worker. Given the extent of betrayal and trauma for Brenda and her family following her experiences and disclosure, her sense of being able to trust her worker was poignant and significant. She later added that to be able to trust her completely took about five months: trust-building was gradual, not instantaneous. From Brenda's mother's perspective, that trust reflected a profound shift for Brenda. Her mother reported that, from being "*initially reluctant",* Brenda went on *"suddenly, absolutely"* to tell her mother:

> *"'Oh yes of course, I trust **[worker]'"**…It's hard to hear that … really, that she could make that strong link with somebody, at that particular point when she trusted nobody"* [Brenda's mother, 154-158].

Chelsey's mother, talking about the first family meeting with the worker, said she saw an instant rapport or connection: "*...as soon as Chelsey met her, they connected straight away"* [Chelsey's mother, 243]. Chelsey's mother was clear about the importance of Chelsey's relationship with her worker for her healing process, noting the significance of connection and that the therapeutic work was rooted in trust:

> ***"**Chelsey had a good relationship with [**her worker**]. She trusted her, which was important, and from that she built on the therapy, and I think if she didn't connect with her then I don't think it would have been successful. And purely because she did connect, and she did get on with her, then it worked for Chelsey, and she trusted, and at that time there wasn't very many people that she trusted apart from mum and dad. So to let someone in, an outsider, was very important, so yeh, trust".* [Chelsey's mother, 413-418]

All parents agreed that their daughters made a "*connection*" (Chelsey's mother); developed a "*good bond*" (Georgia's mother); or had a "*100% positive relationship*" (Brenda's mother) with their own workers in the first phase of the intervention. Darcie's carer commented that Darcie thought her worker "*really liked"* her, *"really listened",* and didn't *"rush"* her, which was especially valuable to Darcie. Georgia's mother specifically identified confidentiality and trust as important ("*…trust is the main thing"*) for her

daughter's engagement in the process and recognised that this was perhaps not easy to achieve with Georgia. Chelsey's mother said that she too took to Chelsey's worker, and could see immediately that her "*personality"*, being friendly and easy to talk to, made her someone who would be "*good for*" Chelsey. For children it is likely to be important that the carer that they trust demonstrates trust and faith in the worker. There is an ironic symmetry for Chelsey and others like her in having to relearn the values of caring and ethical trust since her parents also placed trust in the person who abused her.

6.3.3 Confidentiality and Privacy

Confidentiality and privacy were amongst the key qualities of the developing relationships. Young people did not want others knowing what had happened to them, or that they were seeking help. There is a social stigma attached to both child sexual abuse (Finkelhor, 1987) and to being in therapy. For adolescents whose peer group relationships are important, being different is difficult. Young people who are abused by people they have come to know and trust learn that they are unable to generalise their expectations of trust to all people, even familiar ones. They may fear that other adults, including therapists, might betray their trust or, in the worst case, abuse them (Foster and Hagedorn, 2014). One way young people talked about gaining trust with workers was in terms of maintaining confidentiality and privacy. Three young people – Anya, Georgia and Evelyn – provided clear understanding and acceptance of how confidentiality and privacy worked in their cases. They expressed views that privacy was important, but indicated that they also understood that confidentiality was not absolute, and that being more open carried risks. Still, the fact that confidentiality might not be inviolate and had limits did not diminish their trust in privacy.

Anya, understood from her worker that she would not tell anyone about what they talked about, but that there were limitations of confidentiality: "...*she kept reassuring me every time she told me that she wasn't going to tell*

anybody, only if she had to" [Anya, 244-245]. At the same time, Anya described the environment, the room in which they met, as private: "*in my room, the door was around the corner, so it didn't feel like anyone could walk in"* [Anya, 242-243]. Anya had been offered counselling at school but said that this worried her because it was insecure, people would have known, and it was an intrusion into her everyday space:

> *"People are like 'Ah the school might be quite good, cus you go there every day, you're comfortable there', but I was like "Yeh I like going to school, I'm comfortable there, but I don't want to bring this into school and like feel like teachers are finding out'."* [Anya, 478-481]

Having privacy made her feel secure and confident that her peers and teachers would not ask questions. Dialogues about abuse, like abuse itself, are generally private. There are no convenient conventions for discussing child sexual abuse as there are for other difficult but common scenarios of loss such as bereavement. The underlined 'direct speech' sections in Anya's quote illustrate her reasoning about why counselling at school did not feel right, even though it was a familiar and comfortable space. Anya liked the separation of therapeutic space and everyday space. Seeing a counsellor or therapist in school would have violated that separation:

> *"...it was kept quite separate like therapy and then my outside life. It wasn't like you saw her [therapist] around or like met her outside there...It was separate, but in a good way."* [Anya, 437-443]

Georgia also described how she gained trust in her worker once she understood that she would not tell Georgia's mother everything Georgia said. This confidentiality was important as she knew that her mother communicated with Georgia's worker. She described herself as someone who found it difficult to talk to her mother or in fact to anybody. She felt she had drifted away from her friends, and no longer had much in common with them: "…*cus I can't talk to anybody. Like I can't talk to my friends, they're not my friends"* [Georgia, 332-333]. Being able to trust her worker enough to share her problems, as well as "*problems that my friends were having"*

[Georgia, 340-341], reduced her sense of isolation and helped her believe that her worker was interested and cared about her.

Evelyn explained that she could trust both her mother and her worker and could talk to them both, but implied that she told them different things. She reasoned that she could talk to her "*counsellor*" about matters that would upset her mother. As she gained trust in her worker, Evelyn understood that her worker would not become upset, which encouraged her to share private feelings and details about her abuse which she had felt unable to tell her mother. She felt that her worker's explanation that all work she produced was hers and that she could take it all home at the end if she wanted showed that other people would not be able to see it even after she left.

Young people recognised changes in themselves as their sense of safety, feelings of trust and understanding of confidentiality in the relationship grew. These relational qualities enabled them to feel they could be more open, and participate in dialogue and activities with their practitioners. Anya explained that her worker's demeanour with her made her feel relaxed and comfortable and think that her worker understood her, which helped her be "*able to be honest":*

> ***"...*** *she kept reassuring and I think that's one way the relationship got a bit better, because then I was able to trust her and like become more open, whereas at the start of the sessions even though we went on certain areas she wanted to go on I wasn't as open with her and stuff, telling her everything."* [Anya, 254-258]

Heather and Georgia also described gradually becoming more open and talking more. For Heather, being more open was related to the positive feeling that she could share anything with her worker, even if she thought nothing changed as a result. The relationship kept her returning for her sessions because *"I could talk about my problems with no one moaning at me"* [Heather, 370]. For Georgia, being open meant being able to see her worker even if she was in a bad mood, something she was unable to do with

anyone else. Keeping what she said and did in the safety of the space she shared with her worker separate from her everyday space was important, Georgia explained the limits of confidentiality in the following way: she knew that if her worker thought something "*major"* was going on in Georgia's life – "*like if it was so major that I was at risk"* [Georgia, 395] then she would have to talk to someone else.

6.3.4 Discussion

Exploring interview accounts to gain insight into how young people and workers dispelled anxiety and developed relationships of safety provides information useful to practitioners. Some anxiety is expected in any new encounter, but young people's sexual abuse experiences potentially heightened their worries. Goelitz's and Stewart-Kahn's (2013) reference to isolation in the quote opening this chapter emphasises the aloneness which CSA can engender. Isolation relates not only to physical separation from others but to emotional separation: the secrecy and helplessness described by Summit (1983), and the stigmatisation and powerlessness of Finkelhor's (1987) traumagenic dynamics. Part of the therapist's goal is to make connections with young people so that they feel less isolated by their abuse experiences, and more able to talk. The therapist's role is "*that of a conversational artist… whose expertise is in the arena of creating a space for and facilitating a dialogical conversation"* (Anderson and Goolishian, 1992:27).

Herman (1992:155) describes the "*central task"* of the first phase of recovery from trauma, as *"the establishment of safety."* Bowlby (1988) also emphasises the need for security and safety in a therapeutic relationship, stating that the first of five therapeutic tasks is to provide a "*secure base*" (Bowlby, 1988:156) a concept akin to the relational safety which practitioners and young people aimed to establish. Young people's accounts of developing of relationships in therapy highlighted the significance of constructing a private, confidential and safe space to talk or think about difficult things, to be allowed to express feelings, and, as Anya and Darcie

said, to "*be myself".* It was different and separate from young people's "everyday space" – the world of family, friends, school, familiar routines and everyday life, where they did not talk about their abuse. It was an inclusive space characterised by a feeling of connection, closeness and purpose. For young people whose experiences of sexual abuse included feelings of separation, isolation and hopelessness, the inclusiveness of the relationship was important. The importance their accounts placed on developing a warm and comfortable relationship with workers appears to support the finding of Faw et al (2005) that the bond may be the most important element for young people. Their comments about feeling anxious replicate the findings of Foster and Hagedorn (2014) whose young participants shared similar views about feeling nervous and distrustful at the beginning of their counselling.

Children's understanding that they would not be betrayed by their workers was important to creating a sense of safety in the relationship. Trust is central to interpersonal social relationships, relating to dependence, confidence, identity, certainty and sense of security. Rotenberg et al. (2005:271) describe interpersonal trust as the "...*cornerstone of society and the 'glue' that preserves its stability".* Children's trust in caregivers and other significant adults to support and protect them and in peers to be "*honest, cooperative and benevolent"* is essential for social functioning and self-esteem (Rotenberg et al., 2005: 271). Bannister (2003) holds trust to be a key element of her treatment model, upon which the intervention is based. She proposes that without trust there is no possibility of creating a relationship in which there can be a dialogue about the emotional and relational consequences of sexual abuse and processing of traumatic experiences. Bannister considers betrayal to be a defining feature of CSA, a viewpoint which coincides with the focus on betrayal by, among others, Finkelhor (1987), who describes it as one of the four traumagenic dynamics of child sexual abuse; Summit (1983), who links betrayal and powerlessness with children's accommodation of their abuse; Miller-Perrin and Geffner (1998) who identify betrayal as significant in children's perceptions on sexual

abuse; and Freyd (1996), whose betrayal trauma theory explains both the forgetting of sexual abuse by survivors and also the impact of *"negative social reactions*" to abuse disclosures (Ullman, 2007:21). Young people's betrayal in the act of abuse was compounded by disbelief or challenges by school, family, officials, and court processes. Most guidance for therapists, regardless of theoretical approach (Charura and Paul, 2014), and for social workers engaging in trauma work (Goelitz and Stewart-Kahn, 2013) proposes trust as a prerequisite of an effective therapeutic relationship. Trust can be viewed as an integral part of Bordin's (1979) concept of "bond" – the affective component of the therapeutic alliance, a concept which Paul and Charura (2014: Kindle edition, Ch 1, Sect 3, Para 5, Loc 487) describe as "*mutual empathic understanding and trust".* Professionals who work with children recognise that insincerity and inauthenticity are not successful routes to establishing a trusting relationship with young people, and that honesty, acceptance and understanding the child's perspective are important (Campbell and Simmonds, 2011). Knox and Cooper portray the bond as:

> *"...building a warm, caring, relationship…one in which the client feels heard, supported, understood and accepted… Perhaps most importantly, it is one in which the client is able to trust the therapist, and feels empowered in the relationship*." (Knox and Cooper, 2015:30)

Although the circumstances of young people's abusive relationships was not explored in this study, those young people abused by peers (Brenda, Frances, Anna, and Darcie) possibly had abuse experiences consistent with definitions of CSE. Only Brenda is known to have been exploited, and thus she may have perceived her exploitative relationship as consensual. Her family and the professionals working with her, however, viewed her consent differently. Applying Pearce's (2013) "*social model"* of consent, it is possible to reframe Brenda's consent as 'coerced'. Pearce proposes that young people who give coerced consent understand promises, flattery, gifts and other forms of special attention as genuine representations of attraction or

love, rather than as manipulation, lies and bribery in exchange for sexual activity. One difficulty with young people's participation is that they define their behaviour differently from professionals, so may distance themselves from ongoing dialogues because they perceive they are "in a relationship" or "in love" rather than exploited or abused. Those who define themselves as freely participating in what others see as abusive may "*refute any idea that they are 'in need' of emotional or therapeutic support"* (Pearce, 2010:7). For therapists working with children affected by CSE, what Melrose (2013:16) describes as decisions by young people which "*problematise*" the *"binary*" view of 'child' and 'victim' can create additional barriers to building trusting relationships, because of the potential for a chasm between young person's and worker's view of "the problem" and therefore the solution. If the chasm is deep enough, the earlier quoted line (Section 2.3.6) from McGee and Holmes (2012:447) – *"I'd rather eat glass than sit here and talk to you"* – has particular resonance.

Looking to attachment theory, Pearce suggests, is useful "*to help understand the way that consent is abused through abusive and disorganised attachments"* (Pearce, 2013:59). Building a good therapeutic relationship can help "*counter"* the attachment to an abuser, but it may take time.

Although young people described retrospectively feeling that they could trust their workers early in their relationships, it also appears in their accounts that this experience was not instantaneous and that feelings of safety and trust grew, a finding consistent with Jensen et al (2010). The interpersonal characteristics of the practitioners described by young people coincided with those found by Middle and Kennerley (2001), and resonate with Lefevre's discussion of the value of "*professional use of the personal self*" (Lefevre, 2010:32). Trust at an emotional level involves experiencing relationships as empathic, concerned, caring, and embodying rapport, mutuality and connection:

> *"…people trust others because they feel relational connectedness within their rapport even if there is no rational foundation for such trust attributions"* (Szcześniak et al., 2012:51).

Emotions are contextual – they originate in social events and experiences (Coulter, 1986). This does not mean that they are not experienced as internal and personal, but rather that what we label as particular feelings – joy, sadness, regret – are connected with experiences and understanding of "*responses, actions, appraisals and situations in the social world*" (Coulter, 1986:122). Trust is forward looking, built on social customs and conventions and involves risk. In therapeutic relationships, trust is considered essential for the relationship to have meaning:

> *"Trust is required for supportive relationships to be successful. By having relationships with people who were perceived as trustworthy, participants reported they had the opportunity to disclose their painful past and learn that others may share a similar experience, which ultimately assisted in alleviating their sense of isolation and enhancing their ability to connect with others."* (Arias and Johnson, 2013:831)

Young people's accounts convey this perception of trust. Further, the concepts of confidentiality and privacy were important to trust development: young people understood that they had some control over who knew what they were talking about with their therapists. Messenger and McGuire (1981) found that young people's concept of confidentiality evolved according to guidelines offered by professionals, and that older children (aged 12-15) had a better understanding of confidentiality than younger children (aged six to eight) and expressed strong opinions about confidentiality breaches. It is worth noting that the young people interviewed in this study were aged 11 or older; younger children might have provided different views. One of the significant messages for practitioners from the Messenger and McGuire (1981) study is that it is the young person's perception of confidentiality violations that is important in terms of impact on the quality of the relationship and the progress of the therapy.

6.3.5 Summary

The quantitative section (6.2) demonstrated that in general young people's experiences of building relational bonds at an early stage of therapy were positive. In interviews, young people supported this finding, offering unique perspectives on developing therapeutic relationships, with a common emphasis on trust, safety, confidentiality and privacy. All young people were to some degree apprehensive at the start of the intervention, and described how they felt their practitioners helped them to overcome anxiety. The following section presents practitioner perspectives on the same process.

6.4 Practitioner views: establishing safe relational spaces with young people

> *"You know you can't just expect kids to trust you. You have to do something to earn that trust."* [Anya's worker, 510-511]

Unlike young people, trained practitioners begin a relationship in therapy with knowledge about child sexual abuse, trauma, and therapy, with information about the child and family with whom they will be working, with expectations about the process and what might help or hinder engagement, and with understanding of the basic elements and importance of a "therapeutic relationship". Workers described a range of approaches, models and training or qualifications, which included social work, play therapy, trauma-based work, counselling, music therapy, cognitive behavioural therapy, solution-focused approaches, and specific psychotherapeutic techniques such as *EMDR (Eye Movement Desensitization and Reprocessing)* (Adler-Tapia et al., 2012). In addition, practitioners were conscious of working within an organisational structure with an expectation, incorporated in the written guidance, of providing safety in work with children and young people through the supervision structure. Workers mentioned the value of their own supervision in supporting their relationships with young people and their families.

The main themes in practitioner accounts developed in line with those described for young people, as *Figure 11* shows:

Figure 11: Young people's practitioners - creating a safe space

Practitioners with young people – creating safe spaces	
Theme	Subcategory
Safety	• Connecting • Cocooning the relationship • "Be Myself"
Trust	• Countering betrayal • Ensuring stability • Believing • Accepting young person's expertise
Confidentiality	• Relational space • Confidentiality limits – negotiating sharing

6.4.1 Safety

All practitioners emphasised the importance of connecting with young people at the beginning of the process. Practitioners found they connected at different points; for some, the establishment of a safe relational space took longer than others. For example, Chelsey's worker felt there was an almost instant connection; Frances's worker was not sure that she ever really connected with Frances or gained the level of trust she hoped for, a feeling that is reflected in her responses on the TASC (Chapter 5, Section 5.4.6). Darcie's worker commented that "*first impressions really count"* so planned carefully for her first meeting with Darcie and "*tried to tune in to her... be with her"* [Darcie's worker, 26-28]. She said that she and Darcie "*hit it off from the start"* [Darcie's worker, 31] and characterised their relationship as trusting and "*reparative*". She drew an analogy with attachment theory in her description of safety in the relationship being represented by Darcie's ability "*to sort of like use the relationship just like a secure base"* [Darcie's worker, 18-19]. These statements reflected what she described as her background in person-centred and attachment work. Evelyn's worker, similarly, found an

instant connection. She had prepared for her first meeting and found that the mother-daughter conversations about the potential of the therapy ensured that issues were "*very much present for them"* [Evelyn's worker, 14].

Georgia's worker found her initially "*ambivalent", "unsure" and "quiet"* but also willing to attend. She commented that:

> *"I think it did take a bit of time to kind of trust me and open up to me, and her mum had said that in the past she had kind of been let down by workers, so I think at the beginning they were both maybe a bit ambivalent about how this was going to be."* [Georgia's worker, 11-14]

The practitioner said that just listening, ensuring that Georgia knew that when she talked her worker would hear her and that she would respond differently to other adults in Georgia's life helped them establish a connection. She felt that Georgia grew to see her as a sort of a friend, and a supportive adult – a combination which represented a different kind of relationship to those she experienced outside of therapy. Practitioners recognised that young people would come to see their relationship as like a friendship, but were careful at the beginning to introduce boundaries that would distinguish the therapeutic role from a friendship role or adult role:

> *"...because you're not a parent, you're not a teacher, ...you're not a friend, it is a different relationship, it's a very different relationship and it's a place where you come to deal purely and simply with this particular issue."* [Anya's worker, 434-437]

Anya's worker's approach was to be honest from the beginning about how she could help, and at the same time was reassuring about her understanding young people's problems. The "direct speech" extract below illustrates how she defined herself in relation to young people:

> *"'I will be with you, I will help you through this, I will support you with this. And you have to be able to tell me when things aren't OK for you, and be honest with me, so, I can't help you if I don't know.'"* [Anya's worker, 250-252]

The support would take place within the relationship, what Anya's worker called the 'space':

> *"You know, your personal space, your private space, your special space, where you can come and you can talk about this, you can talk about all the feelings that you have..."* [Anya's worker, 443-445]

Heather had two beginnings. Her worker made the interesting observation that the second time, despite the time that elapsed since they had last met, she did not feel that she needed to spend time building a relationship (*"do any sort of engagement stuff"* [Heather's worker, 69]). Although they had barely completed the assessment sessions the first time, it seemed that the relational connection they had developed was still there. Heather felt *"sort of safe and comfortable with me"* [Heather's worker, 38-39], and "*settled quite quickly back into talking with me*" [Heather's worker, 68-69].

6.4.1.1 Cocooning the relationship

Relationships can be fragile, and practitioners were aware that the time they spent in the same physical space with young people represented a fraction of their everyday experiences. Agencies working therapeutically with children often insist that children's circumstances be secure and stable before agreeing to accept referrals (Ryan et al., 1995). Many sexually abused children experience disruption and chaos in their social worlds as well as in their immediate families. There can be a number of causes: the symptomatology associated with trauma may affect school performance and relationships; risk-taking behaviour including use of drugs or alcohol may increase; and for some the burden of keeping a secret and pretending that everything is all right takes an emotional and social toll. It may be the family environment which is the source of instability: children who experience intrafamilial abuse often live in families who are amongst "*the least cohesive and most stressful and disorganised"* (Howe, 2005:200). Practitioners working with young people described part of their role at the beginning of their relationships to check that there was sufficient stability in their lives for them to engage in therapeutic work. Practitioner accounts reflected holistic awareness of the child having many social connections, and an

understanding that the relationship they developed with young people would be affected by and would have an effect upon other relationships.

Practitioners for three girls, Brenda, Georgia, and Frances, talked about the effect of each unique social world on the development of a therapeutic relationship. In Georgia's case, her worker was aware that her life was complicated ("*there's quite a lot going on for* Georgia *at the moment"* [Georgia's worker, 82]) and wanted to help secure some order and support ("*we all need to try to work together"* [Georgia's worker, 83]) in order to help Georgia engage in therapy. Georgia's interpretation of these actions was that this was a person who would was on her side, who was prepared to "*fight my corner when I'd been excluded and stuff"* [Georgia, 21]. Georgia's worker was *"open*" about communicating with other people, and also maintained confidentiality, so Georgia was gradually reassured that her relationship with her worker included both privacy and control. "*Sometimes,"* her worker said, *"she just didn't want her mum to know, or the school to know and so there were times where I was just respecting that really"* [Georgia's Worker, 103-104].

In Brenda's and Frances's cases exactly what was inhibiting the development of a relationship was less clear. Brenda's circumstances were complex and distressing for her and her family. The worker was aware of the situation and was also aware of feeling "*stuck*", of thinking that she was missing something. The worker described her *"sense"* that something was "*not right"*:

> *"We began work, and I felt like I had to go to her pace, slowly, slowly and there were a few things that sort of made me think, 'hang on a minute' that was it …that feeling of 'Hmm, there's something a bit more going on here, I'm not sure what'… There was something not right, and I couldn't put my finger on it, we didn't seem to be – she was very much still in that position of 'I'm fine, this is a relationship' you know, 'This is all OK, it's everybody else, I don't need anybody, it's better not to have feelings'– this is really difficult for me as a worker I seem to remember!"* [Brenda's Worker, 32-38; 92-93]

Although Brenda came to sessions she was only superficially "*engaged",* indicating that from the worker's perspective the relationship did not represent a place of safety for Brenda. The worker decided to take a step back, go "*back to where the client is"* [Brenda's worker, 45], moving at the young person's pace, not trying to force her to disclose information about herself, providing her with control over how and whether she gained trust in the worker. In the quotes above and below the "direct speech" content underlined marks the practitioner's recollected internal dialogue:

> *"I think sometimes, when I'm feeling stuck, and it sounds really obvious but it's sort of just go back to where the client is, forget all this stuff in your head where you think things should be, and all the rest of it, where's she at? So I distinctly remember a session where I just thought, right 'I'm just going to sit back and go with her'".* [Brenda's worker, 44-48]

The worker's knowledge of the external circumstances was important in the initial stages of her relationship with Brenda, her highlighting of the impact of child protection and investigative systems on the therapeutic environment revealed the capacity for workers to be sucked into external processes to the extent that efforts to create a therapeutic relationship were compromised. The worker was obligated to participate in multi-agency meetings which created tension in the dual safeguarding/therapeutic aspects of her role and also tension with Brenda and her family, an experience she described as "*exhausting and awful"* for everybody, particularly Brenda:

> *"...looking back I think she was just devastated that this had come out and felt really betrayed… And there was a huge, not just for Brenda but for the whole family, loss of trust in the professionals."* [Brenda's worker, 66-70]

The external structures threatened the progress that the worker had made in building a relationship with Brenda, and made it difficult to cocoon the therapeutic space with the kind of stability the worker would have liked. In addition, the practitioner's understanding of Brenda's experience as a young person who felt betrayed first by the reporting of her involvement in what she perceived as a relationship, and then as therapeutic work progressed by her

realisation of the exploitative nature of the relationship, helped her make decisions about how to proceed, to remain patient, and to continue to listen. It was, she commented, almost like starting again, and she found it important to make sure that Brenda could feel that her worker was on her side.

Finally, Frances's worker described similar difficulties making a connection with her and compared her experience to other young people she had worked with. Like Brenda's worker, she sensed that there was something that she was missing or failing to do that might have helped:

> *"She was always very quiet, actually, and it felt harder to develop a relationship with her, to the point where actually I was sort of bringing it to supervision and saying 'I don't know if I can ... is there something I'm doing wrong, am I struggling to engage her?'"* [Frances's worker, 11-14]

The worker described characteristics of the young person which made building a relationship awkward. As well as questioning her own skills, she considered whether there was something in Frances' social world that was creating that tension. Alternatively, it is possible that, like Brenda, if what Frances experienced was a form of CSE, then engagement with therapy would be more problematic, and Frances may not have reached a point where she had resolved for herself the nature of her relationship with someone she had referred to as a "boyfriend".

6.4.2 Trust

Practitioners also described communicating their trustworthiness to individuals who were, as Brenda said, not feeling "trustworthy" towards anyone. Georgia's worker reflected that trust-building was "*gradual"*. Practitioners mostly discussed trust in the context of the young people with whom they worked, but also referenced trust-building in engaging children in therapeutic work in general. Brenda's worker, for whom trust-building presented "*a huge part of the work"* [Brenda's worker, 202], stated that "*you can't go into working with trauma until you've got a trusting relationship and you've got stability"* [Brenda's worker, 30-31]. The stability referred to

circumstances outside the relationship, suggesting that trust-building occurs in the context of young people's social worlds.

Brenda's worker particularly emphasised trust perhaps because she understood that Brenda's experience of not being believed undermined her self-belief and confidence. Disbelief in general compounds sexually abused children's feeling of betrayal, possibly discouraging them from reporting their abuse. The negativity associated with disbelief from caregivers and significant others is one of the factors likely to increase the harm associated with child sexual abuse (Corby, 2007:207). Additionally, disbelief in the sense of non-acceptance of the young person's version of events was likely to have impacted particularly negatively on Brenda as a victim of CSE.

Chelsey's worker also reflected on the importance of trust-building, noting that Chelsey's family had initially disbelieved her allegation and that her parents' initial response was "*such a big thing for her".* The trust developed in the relationship with her worker played a significant role in Chelsey's ability to move forward. The worker reported that in her second meeting with Chelsey she had asked questions as if "*checking me out, she's making sure I'm the right person for her"* [Chelsey's worker, 376-377]. This was an eight-year-old child who the worker noted was "*assertive*", "*clear*", and "*articulate about feelings*" and seemed to know what she needed. Chelsey's worker was confident in Chelsey's motivation and engagement from that meeting and recalled telling herself at the time that: "'*She's going to engage, and play is going to be the thing that she'll use'"* [Chelsey's worker, 330-331].

6.4.3 Confidentiality

All practitioners discussed with young people and their carers the limits of confidentiality: if there were concerns for a child's safety then workers would need to share relevant information. Anya's worker defined the place where they would work as *"your private space"* [Anya's worker, 434). As the earlier discussion revealed, young people were concerned about sharing their private information. Evelyn's worker recognised Evelyn's concern with confidentiality, particularly in her wish to protect her mother from details

about her abuse that she thought would be upsetting. Her worker related Evelyn's ability to separate what she told her mother from what she told her worker to "*insight into the therapeutic relationship, how she could use her time"* (Evelyn's worker, 64-65). She demonstrated her interpretation of Evelyn's thoughts, observing that Evelyn was

> *"…quite clear about 'I don't feel able to share all of this with my mum because she gets too upset, and I don't want to upset her'. So she was clear in the distinction about what role I could serve, versus the comfort and support she could get at home from her mum"* [Evelyn's worker, 61-64].

Confidentiality in Georgia's relationship was complicated by an ongoing court case which imposed additional limitations on confidentiality. Georgia's worker noted that clarity about the restrictions, driven by policy and pre-trial rules of evidence, was necessary at the beginning of the relationship, and any other choice would have been unfair to Georgia. The worker was aware that the external circumstances potentially compromised both the confidentiality she would otherwise have been able to offer, and the nature of the safe relational space she and Georgia created:

> *"So I sort of explained to her all of that, but that made it a bit different I think, for her, cus it's sort of like telling somebody this is a private space for you, but because of the current situation..."* [Georgia's worker, 33-35]

This was a case where Georgia's mother worked together with both workers to support Georgia over what was turbulent period. The worker, like Evelyn's worker, noted that she was someone that Georgia grew to trust with her personal feelings and things that she would not want to tell her mother. This point acknowledged Georgia's wish to be able to talk to someone who would not react as she expected her mother would. In reflection, the worker summed up the relationship:

> *"It was an interesting relationship really, cus ... on the one hand I think she saw me as a bit of a friend really, as support for her, but then on the other hand kind of an adult that was able to support her to make*

some changes and do it quite – without getting emotionally involved." [Georgia's worker, 173-176]

This sense of balance between intimacy and emotional distance is characteristic of the working relationships with young people, and something that young people recognised in their descriptions of workers as ***like*** friends, or ***like*** family members. It is a balance achieved by a combination of the empathic and caring nature of therapeutic work, the skill and knowledge which underpins it, and the reflection and supervision which supports it.

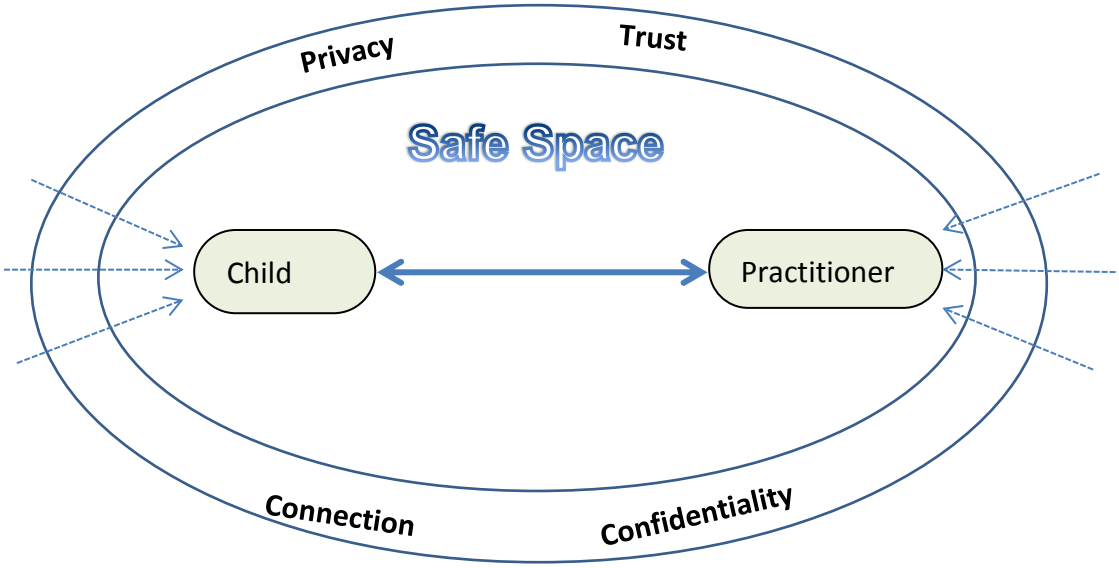
6.4.4 Discussion

Practitioners in this study provided complementary perspectives on establishing safe spaces with young people, focusing on how they used their knowledge, professional training and interpersonal skills, their awareness of context in individual cases, and their understanding of trauma and betrayal. They described a range of backgrounds and training but regardless of experience and approach they focused in their work with young people on developing a relationship characterised by safety and trust before attempting to address trauma issues with young people. The skill and techniques necessary to build such a relationship, "*to instil confidence and trust within the therapeutic frame"* are widely accepted as "*essential to therapeutic success"* (Ackerman and Hilsenroth, 2003: 3). This focus was in line with the intervention guidelines and ethos, and supported young people's accounts of their relational experiences. It reflects what Gil (2012:258) describes as "*laying down the foundation of relational connection",* building a physical, social and emotional environment which incorporates familiarity, choice, control, trust and an unhurried pace that matches children's requirements. This last requirement resonates with Herman's advice (1992) to avoid:

> *"...premature or precipitate engagement in exploratory work, without sufficient attention to the tasks of establishing safety and securing a therapeutic alliance."* (Herman, 1992, 1998:172)

As with young people, the themes are interlinked. It is helpful to conceptualise confidentiality, trust and privacy and connection as all contributing to the creation of a space of safety:

Figure12: Safe Therapeutic Space



In this model, each young person and practitioner brings to the space experiences of other relationships past and present (arrows pointing inwards) which help determine how they interact with each other and the nature of the process of developing a therapeutic relationship. The safe space they construct together is the space in which they can work on whatever problems arise.

6.4.5 Summary

Practitioners talked about characteristics and attributes of young people and how they worked together to create a safe relational space. Their accounts of how they worked to lessen young people's anxieties and build trust were recognisable in the young people's reports of what helped them engage. Workers recalled their feelings and responses to building the relationship and working with each young person. Young people identified qualities – warmth, friendliness, and calmness for example – which they thought helped

create a relational and physical environment experienced as separate from everyday spaces of school and family. The context of protection and safety for young people was represented not only in practitioners' practice of transparency about confidentiality limits, but in their efforts to promote the feeling of safety within the relationship and to cocoon it from the impacts of events and processes affecting young people in their everyday spaces.

As the carer intervention offered a non-therapeutic service, the accounts of developing a working relationship between parents and practitioners could differ from those provided by young people and their workers. The following two sections present and discuss the themes developed first in parent interviews and then in practitioners accounts.

6.5 Parents' views: developing a working space

Parents provided varied perspectives on the development of their own relationships with workers, on their children's relationships with their workers, and on their relationships with their children's workers. This section explores the relationships parents described with their own workers. The intervention offered "safe carers" a service aimed at helping them to care for and support their children during and after their therapeutic sessions. As the parent service is not therapeutic, it is not premised on the same level of trust and safety as is necessary when working with traumatised children. It is limited to a maximum of eight sessions, leaving no time for the kind of depth and comfortable pace afforded young people. The expectations for the worker-parent relationships and the outcomes are different from those for children. Further, parents were adults who brought to the relationship a variety of life experiences and developmentally different cognitive and emotional understanding of relationships in general and therapeutic relationships specifically.

From carers' perspectives, the pattern of developing working relationships was diverse. Two accounts, from Evelyn's and Chelsey's mothers, stood out as presenting views of relationships that shared some characteristics and patterns with young people's therapeutic relationships. Brenda's mother's

account was unusual in the negotiated boundaries and roles which set the pattern for working together as a couple with their practitioner. Georgia's mother and Anya's parents presented views of developing a working space that were quite different, although they shared some common features with the other three. In the following sections, commonalities in all accounts are described first, followed by more detailed presentation and discussion of Brenda's, Chelsey's and Evelyn's mothers narratives.

6.5.1 Common features in parental accounts

Figure 13: Parent perspectives on creating a relational space

Parent perspectives – creating a relational space	
Theme	**Subcategory**
Confidence in professionals	• Reliability • Knowledge • Skills
Personal characteristics	• Listening skills • Empathic stance • Warmth and genuineness
Safety	• Trust • Clear boundaries • Not judging

Parent interviews offered views on positive characteristics of workers which helped them form working relationships. Belief and knowledge that workers were reliable, informed, and dependable were important. Parental accounts noted common personal characteristics, qualities such as "*easy to talk to"* or "*get on with"*, "*comforting"* and *"comfortable"* [Chelsey's, Georgia's, Evelyn's parents], "*not judging"* or "*non-judgmental"* [Georgia's and Evelyn's mothers]; *"listener"* [Brenda's and Chelsey's mothers]; *"caring"* and "*empathic"* [Evelyn's and Anya's parents]. Anya's parents viewed the relationship as providing a "*space to talk"* [Anya's father, 192], made possible because their practitioner was "*chilled"* [Anya's mother, 193]. These qualities made

workers appear warm, welcoming, and genuine. Regardless of any hesitant beginnings, all parents and workers negotiated sound relationships which constituted what might be characterised as a "safe enough" space, or a "*supportive space"* [Brenda's mother, 45] in which to focus on issues related to supporting children who had been sexually abused, and all ultimately believed the worker to be the "*right person"* [Brenda's parents] for them. Chelsey's mother said that she looked forward to going to her sessions despite the difficulty of dealing with issues related to her daughter's abuse, and summed up the importance of connection:

> *"I think the relationship you first have with your worker determines how your therapy will be... at the start, because I'd not experienced it and I didn't know what to expect and know kind of how to talk to a stranger, someone I didn't know, at the beginning, but within a couple of weeks, and that's due to* ***[worker]*** *and* ***[child worker]****, their personality, and how they connected with me really – I found it easy to talk to them*." [Chelsey's mother, 426-428; 431-434]

6.5.2 Safety and trust

Brenda's, Chelsey's and Evelyn's mothers portrayed the beginning of the relationship as involving development of safety and trust in a similar way to young people. Mothers of all three young people were deeply distressed by events to the extent that even recalling the positive relationships and outcomes associated with the intervention triggered emotionally painful memories of the experience which made them tearful: *"...it's been the most difficult time for all of us, of our lives"* [Brenda's mother, 261]. Each woman's account was poignant and moving, and their reports of building a relationship with their workers reflected the unique circumstances of each case.

For Brenda's parents, the process of creating a working space which was emotionally safe enough was paramount, and illustrates the importance of context in the parent service. The concept of relational safety denoted in Brenda's mother's account is one where agreed boundaries were respected and in which she had a choice not to go where she felt vulnerable. Through

her professional work she had greater knowledge of therapy and therapeutic relationships than parents of other children, but like them was not at first sure what to expect from the intervention. They were clear with their worker that they did not need information about CSA: *"I think they listened to us when we said, 'Don't really need educating'"* [Brenda's mother, 44]. They negotiated a role which they thought would represent the best use of a brief relationship. The role was as facilitator of a "*supportive space"* which was *"very important at that time"* [Brenda's mother, 44-45], a "*witness"* to parental dialogues about the manner in which they were coping and keeping life in the everyday sphere going amidst the trauma and chaos of abuse:

> *"We hardly ever spoke to each other while we were just dealing with what we were dealing with. We had an absolute understanding that we were both getting on with it, and on the same track, but we never had really time to discuss how we felt about it... So I think those sessions we used very much to say 'Good grief, hasn't this been horrendous'.*" [Brenda's mother, 23-26]

Brenda's parents' professional roles affected their approach to the relationship with their worker and their first interactions. As Brenda's mother said, "*When I met [worker] I found myself slipping into the other side, and thinking 'He looks very young'*..." [Brenda's mother, 63-64]

The "other side" was her own memory as a young and inexperienced worker recalling feeling that "'*nobody is going to listen to me because I have no experience', but people did, and they trusted me, and that's how it works"* [Brenda's mother, 58-60]. She portrayed their worker as "*extremely nervous*", a description which the worker confirmed in his interview. Confidence in the practitioner's professional knowledge and skill was important and she talked about his self-disclosure at the beginning as honest though perhaps unhelpful:

> *"I think he said openly, 'I haven't got any experience of working with parents', so, in a way I wish he hadn't said that... Cus I'd rather not have known...because partly maybe I did think 'Oh, you're young, you've not worked with parents before', so yes, that's my prejudices really rather than – but if he'd have been more, [pause, thinking]*

what's the word, if he'd kept that to himself it may have helped." [Brenda's mother, 71-77]

This passage provides an example of how the "*direct speech"* interview extracts bring people's stories to life and assist in contextual understanding of their recollections of encounters with others. Brenda's mother made points which brought into the present both her thoughts at the time and her reflections on them, and helped to create a rich account of the development of her relationship with the worker. This process is illustrated in *Figure 14* below:

Figure 14: Direct speech and reflections

Lines	Direct Speech (in bold)	Reflections
26-27	We used very much to say ***'Good grief, hasn't this been horrendous'***, and to talk to each other	*[Worker] was almost like a witness to that*
43	We said, ***'Don't really need educating'***	*they listened to us*
58-60	I felt very young, and like ***'nobody is going to listen to me because I have no experience'***	*but people did*
61-62	thinking ***'He looks very young'***	*that's irrelevant*
69-70	I think he said openly, ***'I haven't got any experience of working with parents'***	*in a way I wish he hadn't said that*
72-73	because partly maybe I did think ***'Oh, you're young, you've not worked with parents before'***	*that's my prejudices really*
86-88	*it was almost like '**OK, 2 weeks, 3 weeks' time we'll come in here again, and then we'll be able to have another conversation'***	*we couldn't elsewhere*

Vivian Burr (2003) describes a micro social construction model of self-concept which offers a theoretical framework for examining the 'direct speech' and reflection links described above. Burr's self-concept is seen as "*arising out of reflection"* and introducing the notion of a "*third other"* which influences thinking and action as another person might. In her words this

reflective voice or *"third 'other'... exerts the same pull on my conduct as real interactants"* (Burr, 2015: 218). The figure above, although clearly a retrospective representation of what happened, permits the listener to get closer to the reality of Brenda's parents' experience at the start of their relationship with worker. They asked for a space and a time where they could have conversations they could not have at home, or with anyone in their social world. They wanted this to be facilitated by someone they could trust to be a reliable and present witness and reassurance that the space would be there at times agreed. Finally, Brenda's mother considered carefully whether the worker was the *"right person"* [Brenda's mother, 272] because feeling comfortable with and trusting of the person in the space allowed the couple to talk about distressing experiences. Her reflection that he was "right" enabled them to continue.

Chelsey's and Evelyn's mothers' accounts of engaging with practitioners were different. They approached the service with feelings of betrayal, trauma and isolation. Both women experienced shock, ongoing distress, powerlessness and isolation in the aftermath of their children's disclosures. Evelyn's mother described her reaction as the moment when "*your whole world sort of falls to pieces"*: *"one thing"* her daughter said *"that brought my entire world to a standstill"* [Evelyn's mother, 30; 544]. For the experience to be represented by the "world" suggests the enormity of the impact on her. For Chelsey's mother, too, the disclosure was shocking, and she described her husband's non-engagement with the service offered as due to it being too "*difficult and traumatic"* to discuss. The level of secondary trauma alluded to indicated that, as for young people, a safe space incorporating trust and confidentiality would provide an environment where parents would feel able to make sense of what had happened. Like young people, both women felt anxious at the beginning and said that it took time before they felt safe – they did not know what to expect. As Chelsey's mother noted:

> *"At the beginning, at the beginning I didn't really know what to expect, it were, cus it were kind of like, letting someone else in, so it was very hard to speak, but I found comfort in her."* [Chelsey's mother, 41-43]

Developing a safe, secure space for both women was linked to gradually feeling relaxed and comfortable with practitioners. Contributing to the growing connection described as "*getting to know each other"* [Chelsey's mother, 128] were positive worker characteristics such as "*the kind of person she was"* [Evelyn's mother, 217]. These characteristics were similar to those provided in young people's accounts: listening, empathy, familiarity, kindness, caring and friendship. Crucial for these mothers also was a non-judgmental attitude. Evelyn's mother had been feeling bad for not being there when her daughter was abused (a "*massive thing for me*") and was worried that "*you are going to get judged yourself"* [Evelyn's mother, 22-23]. Not being judged meant that Evelyn's and Chelsey's mothers felt safe about talking to someone who understood about things they were unable to discuss anywhere else. Evelyn's mother summed up the initial phase of the relationship eloquently:

> *"They almost make you feel like you're the only person they're working with, like this is what they're focused on and it's just a lovely feeling... like this person really cares about you and they don't know you, so, not really, they know one part of you and as the weeks go on obviously they know a lot more, but you've never really spent a lot of time with them, and they can kind of connect to people through certain things, very quickly."* [Evelyn's mother, 367-373]

6.5.3 Discussion

The importance of safety, trust, confidentiality and privacy in parent-practitioner relationships and the extent to which these qualities were achieved varied, reflecting the limited, non-therapeutic structure of the service. Two parents, Chelsey's and Evelyn's mothers, although wanting help, knew little about therapeutic services and took some time to feel able to confide in their workers. Brenda's mother, on the other hand was knowledgeable about therapy and more comfortable and confident about negotiating a way to work together. It is tempting to explain the difference amongst individual parents in emphasis on developing a safe working space

by relating it to different levels of trauma or coping strategies following children's disclosure, but the interview did not seek specific information about parents' feelings or responses to disclosure. There are therefore a number of other possible explanations related to personal and family dynamics – including, for example, timing of parental sessions in relation to the young person's therapeutic progress – and research factors such as timing of interview and parental control in the interview process and content.

Less has been written about the impacts of child sexual abuse on parents than about impacts on children, but clinicians and researchers agree that parents experience secondary trauma and replications of various negative consequences associated with victim experiences such as shock, anger, guilt, anxiety, distress, aloneness and self-blame (Deblinger et al., 1994; Kilroy et al., 2014; Hill, 2001; Manion et al., 1996). As Hill (2001) points out, much of the literature has focused on risk assessment and protective capability of parents – notably non-abusing mothers – rather than on social and emotional impacts. Parents' accounts in this study reveal emotional distress, concern about how they will be viewed by others as well as perceived benefits of relationships with knowledgeable, reassuring, supportive, non-judgmental and caring professionals. The following chapter offers further exploration of how safety and trust in relationships assisted particularly mothers to talk about issues and conflicts related to parenting and "bad mother" stories.

6.5.4 Summary

Parental perspectives on the process of engaging with their workers differed from young people's understandings, and from other parents' views. There were some common features: active listening and attentiveness were positive qualities which made parents feel that practitioners were easy to talk to. Displaying empathy and a caring, non-judgmental attitude made parents feel supported and cared for. Chelsey's and Evelyn's parents found the safety of the space offered helpful in enabling them to share feelings that they could not express elsewhere. Anya's and Georgia's parents, whose

accounts focused less on their anxiety about sharing their feelings and more on the experience of wanting help and quickly gaining confidence in their workers as people who could provide it, viewed knowing that the practitioner was experienced and knowledgeable as important. Finally, Brenda's mother described the process of meeting and accepting their worker as the 'right person' for the way they wanted to use the sessions, and negotiating with him the boundaries and purpose of the space they created.

In the following section, parent practitioners present their perspectives on establishing working spaces with parents in the context of an intervention with children.

6.6 Practitioner views: developing a working space

Practitioner perspectives on developing working relationships showed variation and common features, just as parent perspectives did. This section presents practitioner views and focuses on accounts of practitioners who worked with Chelsey's, Evelyn's and Brenda's parents.

6.6.1 Common features in practitioner accounts

Figure 15: Parent practitioner perspectives on creating a relational space

Parents' workers' perspectives – creating a relational space	
Theme	**Subcategory**
Professional knowledge	• Understanding of issues • Specialised knowledge
Personal skills	• Listening • Being available • Flexibility
Safety	• Setting boundaries • Respect, not judging • Acceptance

Workers for parents started by "*just hearing her*", allowing her to "*tell her story to someone who was neutral"* (Chelsey's parent worker); "*letting her say all the stuff that she wanted to say*", providing "*an open space"* where "*she could say anything*" (Evelyn's parent worker); listening to *"what had happened, in quite a lot of detail*" (Brenda's parents' worker); "*making myself available*" (Anya's parents' worker). Parent workers described reflection, empathy, respect, genuineness as helpful in building a relationship where parents felt safe enough to unburden themselves. Listening to descriptions of practitioner approaches to working with parents, it seemed that despite the difference in service, many of the fundamental relational skills they used were similar to those employed in beginning therapy with children and young people. As Anya's parents' worker put it:

> *"I think it's just, I think it's mainly through being, you know, just making myself available, I mean absolutely present with them and listening, and you know, attunement, and empathy, and the kind of classical sort of ingredients really if you like for creating a safe space. And being real – and genuine you know."* [Anya's parent worker, 159-163]

6.6.2 Trust and safety

De-emphasis on developing a 'therapeutic' relationship did not mean that parent workers ignored the need for trust and safety, but they assigned different value to the concepts. As parent interview accounts indicated, the level of trust and safety they felt they needed was variable and dependant on what parents brought to their sessions and hoped to gain. Chelsey's parent worker provided insight into providing safety in the relationship for parents for whom *"providing information was not enough"*:

> *"...as you feel safe, you're able to share more aren't you. And depending on the reaction of that person, depends how you then go on. So I think that she did feel that I didn't judge her, and that I could be a safe person where she could bring whatever, and vent, or whatever she needed to do."* [Chesley's parent worker, 292-295]

Being "neutral" or "not judging" from Brenda's, Chelsey's and Evelyn's parents' perspectives was significant. It is difficult for parents to overcome the sense of having failed to protect (Chelsey's and Evelyn's parents) or to

cope with a child (and by association, parents) not being believed by professionals, if they perceive their worker to be judging. If workers aimed to help restore parental confidence by providing them with information, "normalising" their responses, and reframing the narrative of letting their children down, then they had to communicate the kind of neutrality or acceptance of which Chelsey's parent worker spoke.

Evelyn's mother also had "*so much she needed to share"* in her first session, as her worker noted that "*there was no space to do any of the work that I tentatively thought we might do"* [Evelyn's parent worker, 336-338]. She felt it was necessary to create a space of safety and trust, as she would do with a child in therapy:

> *"There's some common themes I would say, in terms of building up trust and making people feel safe in the space and that kind of thing, I think that the focus is slightly different because when you're working with children it's more directly about their experience of sexual harm, whereas we try to sort of, the work that we've done with parents and carers is more about helping them support their child rather than just work on their own issues*." [Evelyn's parent worker, 232-237]

Although similar practitioner skills are required, there is a difference of degree in work with children and work with parents in this intervention: workers not offering a therapeutic service do not wish to encourage parents to share personal difficulties unrelated to supporting children and which workers were unable to help them resolve. Therefore, at the beginning of the relationship the worker sought to provide clarity about boundaries. Chelsey's parent worker summarised the relevance of boundary setting to the relational space:

> *"My time's limited... so 'What can I achieve in this time that's gonna leave her feeling better, and not undoing anything that I can't put a lid back on', it were that kind of thing as well, you know, it was 'What feels ethically right?' I suppose."* [Chelsey's parent worker, 203-206]

As noted above (Section 6.3.2), Brenda's parent worker agreed that he was nervous and inexperienced working with parents. He described feeling

initially deskilled and somewhat intimidated by his perception of parents' professional status, and also upset at unexpectedly hearing a detailed description of events and their distress. He talked of feeling at first "*helpless", "clumsy"* and *"powerless"* despite his experience, and offered an interesting insight: "…*there was something about working with them that made me do that, I wasn't just, it wasn't just a bad day*" [Brenda's parent worker, 240-241].

Like Brenda's mother, he characterised the beginning of the relationship as tentative, involving negotiation leading to mutual understanding and acceptance. The role he expected to have of supporting, educating and advising appeared inappropriate:

> *"A certain feeling of helplessness that I felt, which in part was perhaps triggered because of the fact that they were very professional people, very well educated and articulate, and good at expressing, you know, what they'd been through, and also the limitations of what I was able to offer them in that time."* [Brenda's parent worker, 24-27]

As other practitioners noted, reflection was helpful. Brenda's parent worker talked about accepting what parents brought to the first meeting – their mistrust of professionals, their distress, and their questions about his experience – and then monitoring himself in his interactions with the couple. Monitoring included re-establishing his own confidence and reminding himself that "*I can offer them something"* [Brenda's parent worker, 216] and, in parallel to therapists' technique of "normalising" parental responses to children's disclosures, recognising that he was not the only professional who might feel confidence undermined by circumstances.

6.6.3 Discussion

One notable difference between parents' and young people's practitioner accounts of creating a safe relationship was absence of reference to a long rapport building phase for parents. This was in part dictated by the limitation on sessions and lack of necessity to prepare parents for therapeutic work. A

related point was that the service was optional and focused on the child's needs, not the parents' and was therefore potentially less personally threatening and intrusive for parents. In addition, many parents using the service could immediately make use of written educational material about CSA introduced in a first session. Finally, because parents attended the service with questions and concerns about supporting their children, practitioners first focused on listening empathically to parental concerns and issues rather than on activities and conversations aimed at gaining trust. This activity helped parents and workers connect.

Parents' practitioners acknowledged the differential parental impacts of child sexual abuse in their interactions and were responsive to parents' need for reassurance, safety, trust and a non-judgemental reception. Judgmental attitudes are related to power in relationships, real or perceived. Absolute neutrality is not possible to achieve as therapists are "*value sensitive*" (Gergen, 2009:138); professional behaviour is not value neutral, and Efran and Clarfield (1992) suggest that pretending that it is actually undermines the genuineness and respect which therapists aim to demonstrate in relationships. Practitioners are encouraged to establish relationships in therapy and social work practice which favour mutual respect, empowerment and choice, and to emphasise making the partnership work.

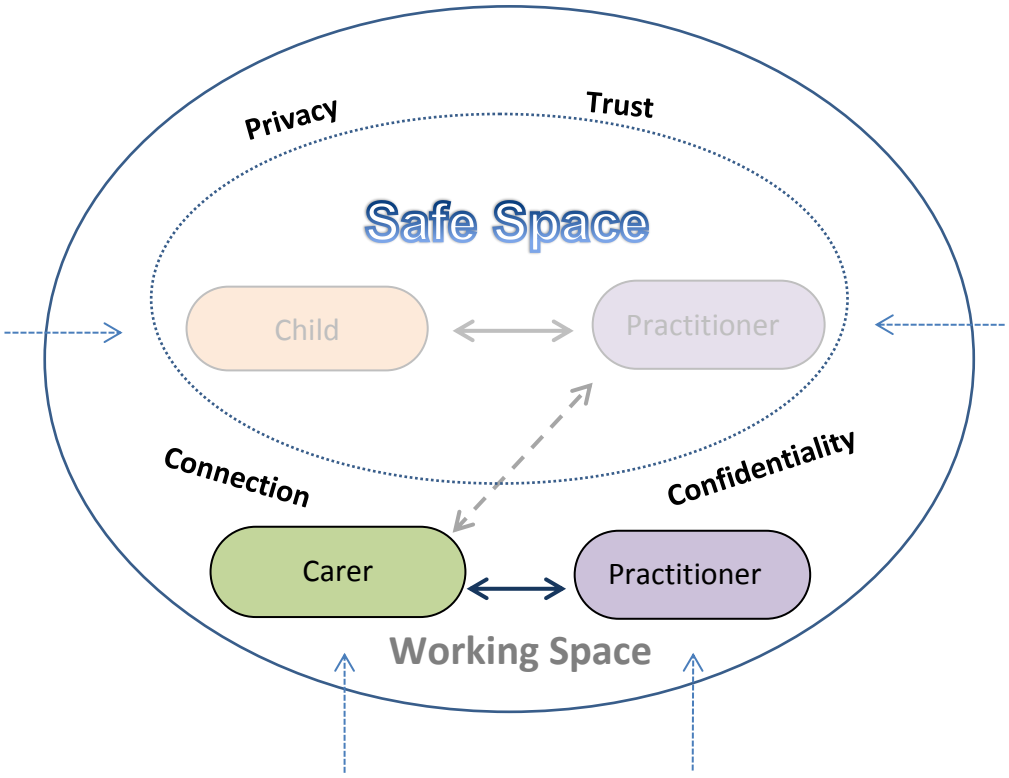
Efran and Clarfield (1992) contend, however, that it is no more possible to eliminate inequalities in power, or hierarchy, than it is to be genuinely value neutral or apolitical. Therapists have training, knowledge and experience that is inaccessible to most help-seekers, who therefore bring their problems to therapists. This view does not contradict a worker's acceptance that clients are the experts in their own problems – they have different expertise. The therapist in turn, has a responsibility to use their skills and knowledge ethically, recalling the discussion in Chapter 4 (section 4.4.6) about ethical relationships of support (therapy) and enquiry (research) versus unethical relationships of abuse.

The existence and expectation of hierarchy in therapy provides a possible explanation for the initially unsettling experience of feeling "*de-skilled", "helpless"* and *"powerless"* related by Brenda's parent worker. Brenda's parents did not want therapy or expertise – their knowledge and experience were unexpectedly similar to the worker's. He anticipated being able to inform, educate and help parents process the impacts of disclosure, but this couple had their own idea of what would help. Negotiating at the beginning of a relationship how to use the therapeutic space, or the working space, is a common process in person-centred, client-led relationships, and the next chapter returns to issues of judgment, power, control, and choice.

6.6.4 Summary

Practitioner perspectives on the relationships they had with parents were consistent with parent perspectives. For young people's workers, the development of a safe relationship in which to address issues related to trauma was a prerequisite; for parent workers, neither guidance nor common practice stipulated the same kind of relationship. Nevertheless, as in parental accounts, workers reported aspects of parent-worker relationships similar to those described in young people's relationships, as well as aspects unique to working with parents. Parent practitioners appreciated the differences in each family's situation, approached the first meetings with open minds, and were prepared to be flexible, working within agency and intervention boundaries. Where parents reported anxiety or uncertainty when they first met workers, practitioner perspectives accounted for their acknowledgement, understanding and responses to these feelings. *Figure 16* illustrates parents' relationships with practitioners – their own and their child's – not within the safe space for children, but linked with and intersecting it.

Figure 16: Parents and practitioners – working space



6.7 Chapter Summary and Conclusion

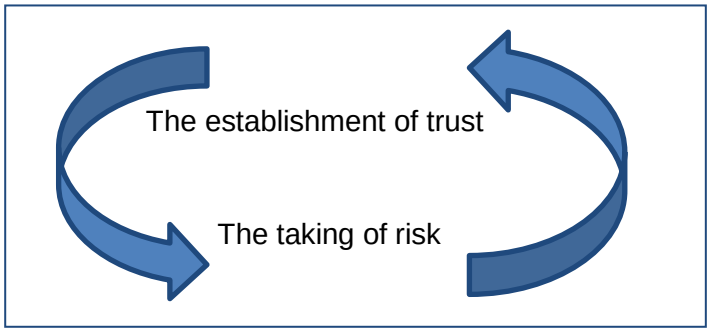
> *"If the trauma of abuse is to be dealt with in treatment, the therapy has to be based on a genuine and authentic relationship that relies on the formation of trust between client and clinician."* (Nelson-Gardell, 2001:412)

Participant accounts of the development of relationships in therapy highlighted that constructing a safe space was key for young people, and also for some carers. This was a space to be private, to "*be myself",* to talk or think about difficult things, to be allowed to express feelings. It was different and separate from people's "everyday spaces" – the world of family, friends, school, work, familiar routines and everyday life. It was an inclusive

space characterised by a feeling of connection, closeness and purpose. For young people and parents in this study whose experiences of sexual abuse included varying degrees of separation, isolation and hopelessness, the relational spaces provided in the intervention were significant.

Developing trusting relationships is not risk-free: as the discussion about betrayal and trust suggests, trusting also incurs risk. In creating a relational bond involving trust, the potential for breaking the bond is recognised. For young people trust was signified by a belief that workers would not tell, would keep the space private, would honour promises and be honest about limitations; for some parents trust similarly emphasised confidentiality and for others meant being able to rely on information and advice, and having confidence in practitioners' knowledge and skills. Mason (2005) suggests that trust and risk are in a relationship of "mutual influence" and provides the diagram presented in *Figure 17:*

Figure 17: Mutual influence in risk and trust (Mason, 2005: 164)



Risk-taking for young people was illustrated by their anxiety in the early stage of relationships, in their preparedness to consider being open and sharing personal information and feelings, and, as is shown in the next chapter, in their engagement with what was presented by the potentially scary phrase "trauma-processing". Risk-taking for practitioners was reflected in the concerns that they might miss something, get it wrong, or permit

reactions like secondary trauma to adversely affect the relationship. For practitioners and young people/parents, as improvements were observed and as is described in the next chapters, the risks taken seemed worthwhile, and trust well-placed and reinforced.

7 Chapter 7: Working in the safe space

> *"I think all of those little bits that we sort of did helped the relationship to then get stronger and helped her to feel that she could talk about how she actually felt and what was going on for her."* [Georgia's worker, 134-136]

7.1 Introduction

Shirk and Saiz (1992:718) found that conceptually and empirically it made sense to distinguish affective experiences from task-orientated experiences. Following their lead, this chapter focuses on the interactions, conversations and activities which took place within the context of the safe relationships described in the previous chapter. The relationships established early in the intervention set the scene for the work that followed, and the sections below examine participant perspectives on working within the space created. The concept of "working" is contextual – its meaning is culturally, socially and developmentally sensitive. In this context, "work" refers to participant accounts of what happened in sessions, both content and process. The discussions entail a qualitative understanding of Bordin's (1979) collaboration on tasks and Gergen's (2006:44) view of therapy as "*collaborative action"*. Findings are presented as in the previous chapter beginning with a brief analysis of TASC scores on items related to collaboration on tasks for youth and workers. The subsequent sections examine the perceptions of young people and practitioners, then parents and practitioners. The final section presents a conclusion.

The chapter addresses research questions 2, 3, 4, and 5.

- Research question 2 asks how the concepts of bond, collaboration on tasks, and agreement on goals are manifested in the intervention. This question is explored quantitatively in examination TASC scores for young people and their workers, and qualitatively for all groups, focusing on tasks and the process of working together.
- Research question 3 asks how children and therapists saw the relationship develop and change during the course of the intervention.

As parents and practitioners noted changes in their relationships these are also discussed.

- Research question 4 is concerned with the characteristics associated with developing therapeutic relationships, and this chapter reports on participant characteristics relating to collaborative working.
- Research question 5 asks about patterns observed in creating and maintaining relationships. Patterns are identified in the themes explored throughout the chapter.

7.2 Analysis of TASC Scores – collaboration on task scale

This section analyses the items on the TASC related to collaboration on tasks in as Chapter 6 (section 6.2) did with bond items, making comparisons with the evaluation sample from which the study sample was drawn, and examining scores on task items for young people and workers.

7.2.1 TASC: youth and worker scores related to children aged 7 years and above, task items

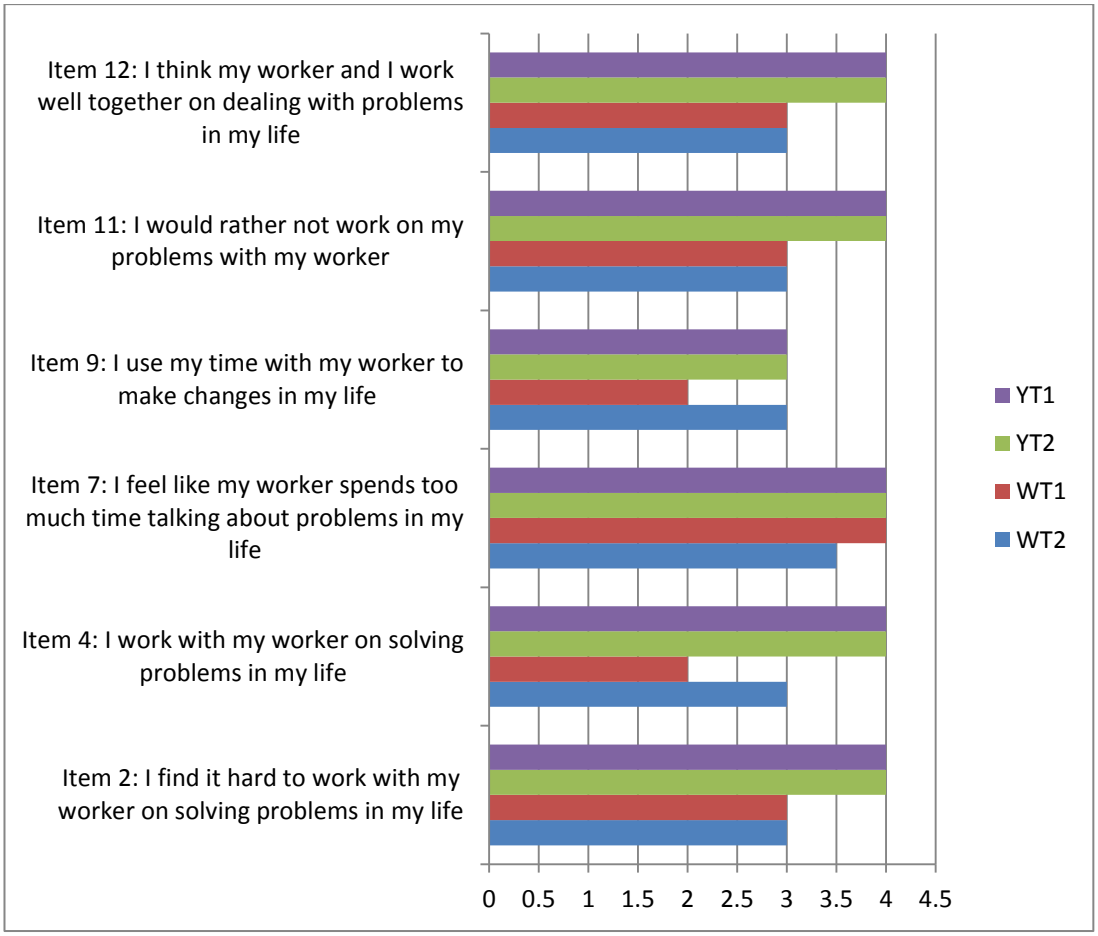
Six "task" items, referring to how children and practitioners viewed working together or solving problems, are analysed in this section. As in Chapter 6, only children in the study sample aged 7 years and above (n=126) are included in the analysis and discussion. The maximum total score for the six questions is 24, minimum 6. Median total task item scores for children (n=67, one more child completed the task items than the bond items) who completed scales both times were: T1 21.0 (IQR = 19.0 – 23.0) and T2 21.0 (IQR= 19.0 – 24.0). A Wilcoxon Signed-rank test determined that there was no statistically significant median change in total task scores for children aged 7 years and over between T1 and T2 ($Z = .880$; $p > .05$), indicating virtually no effect.

Median total task scores for practitioners (n=72) who completed the scales both times were: T1 17.0 (IQR = 15.0 – 20.0) and T2 18.0 (IQR = 16.0 – 20.0). A Wilcoxon Signed-rank test determined that there was a significant

median increase in total task scores for practitioners between T1 and T2 (Z = 2.569; p = .010), indicating a small effect (r = 0.17).

Matched pairs (those who completed the scales both times) were selected to analyse each individual question to examine change between T1 and T2. The results are shown in *Figure 18.* The figure illustrates, as with bond item comparison, the positive overall picture provided by both groups, but also shows that the medians of young people's scores tended to be a score point higher than workers' median scores (for analysis, items 11, 7 and 2 are reverse scored):

Figure 18: Median task scores, youth and workers T1 and T2



Each individual question was analysed using Wilcoxon Signed-rank test. None of the differences in the medians between T1 and T2 for the youth group were significant. However, on items 2 ("*I find it hard to work with my*

worker on solving problems in my life") and 7 (*"I feel like my worker spends too much time talking about problems in my life"*) there were interesting though not statistically significant shifts in scores. On item 2, 60 percent of scores (n=40) remained the same at both completion points, but of those scores that changed, twice as many went up as went down. On item 7, the opposite occurred: 70 percent of scores (n=47) remained the same at T1 and T2, but of those scores which changed, 13 went down and 7 rose.

In the worker group, at least half of the scores remained the same at T1 and T2, and on no item were negative shifts in scores greater than positive shifts, indicating general increase in positive scores between completion points. Three items showed change in the median between T1 and T2 which reached levels of significance. Items 4 ("*The child works with you on solving problems in his/her life")* and 9 ("*The child uses his/her time with you to make changes in his/her life"*) revealed that of those workers who changed their scores, 85 percent ($Z = 4.218$; $p < .0001$; $r = .35$) and 80 percent ($Z = 3.332$; $p = .001$; $r = .28$) respectively provided higher scores at T2. These are medium effect sizes. On item 12 (*"The child is able to work well with you on dealing with problems/issues in their life"*), 49 percent (n=35) of workers provided different scores at T2, and over half of the changes were in a positive direction ($Z = 2.028$; $p = .043$; $r = .17$). This is a small but significant effect.

Comparing the percentages of practitioners and young people who provided low scores (1 or 2) for each item *(Table 3)* is another way of visualising the differences in responses to individual task items:

Table 3: Proportions of youth (n = 67) and workers (n = 72) scoring items 1 or 2 (low)

Items	Youth T1 (%)	Youth T2 (%)	Worker T1 (%)	Worker T2 (%)
2	13.4	10.4	20.8	20.8
4	13.4	14.9	52.8	27.8
7	6.0	9.0	5.6	5.6
9	23.9	19.4	55.6	41.7
11	3.0	3.0	22.2	16.7
12	23.9	7.5	43.1	27.8

The positive shifts in worker scores on items 4, 9, and 12, and in young people's scores on item 12, are evident in the decrease of proportions of scores of 1 or 2 in response to these items. On bond items, generally proportions of low scores were smaller than on task items, and improved at T2.

7.2.2 Discussion

Worker scores on task items vary more than young people's, and although the overall picture is positive in both groups, scoring was slightly lower than on bond items, particularly in the practitioner group. The movement of some young people's scores upward on item 2 and downward on item 7 might be interpreted as indicating that as time goes on they find working on problems becomes easier and as problems are solved, they would prefer to focus less on problems.

Workers' improved ratings on items 4, 9 and 12 may be interpreted as supportive of children's views that working together on problems does not begin immediately but becomes easier as time goes on, although how much

easier and how soon is likely to vary among individuals. Children respond differently to abuse and to offers of help depending on the multitude of other influences on their lives. In the previous chapter, individual young people described the process of developing relationships of trust in their workers differently. For those for whom trust-building is more difficult, or whose lives are more chaotic, the point of being ready to work on "problems" may come later than for others. Regardless of therapeutic approach, stability of the bond in a therapeutic relationship needs to precede activities aimed at processing trauma or addressing complex issues:

> *"Most agree as to the helpfulness of a consistent and containing therapeutic relationship which may start to meet the individual's needs for safety, recognition and reconnection with their self and others, creating a safer environment in which abusive experiences can emerge and be processed…"* (Lefevre, 2004: 139)

Until the kind of safe space and stability described in the preceding chapter is created, working on problems with children in therapy may be both impossible and inadvisable.

7.2.3 Summary

Children's scores indicate positive views on working to solve problems in their lives with workers, and suggest that they feel they work well together and are satisfied to spend their time working on problems in sessions. Worker responses showed less confidence in children's engagement with the problem-solving aspects of therapy, although scores were more positive than negative, and improved at T2. The figures provide a helpful overview of the focus on collaboration on tasks within the therapeutic relationship, and the interaction between the development of bonds and the problem-solving activities in therapy. There are questions the TASC data are unable to answer however: how practitioners and young people make decisions about how to work together; how they decide what problems to focus on; what helps or hinders collaborative working; how important they perceive the safe space to be in the tasks undertaken; and how they acknowledge and understand progress in resolving problems. The remainder of this chapter

and the subsequent two chapters investigate young people's, practitioners' and carers' perspectives on working together in the context of the therapeutic intervention.

7.3 **Young people's perspectives**

Therapists across disciplines view children's participation in therapy as supported by the relationship with the therapist (Garcia and Weisz, 2002; DeVet et al., 2003) and clinical experience with children and adolescents evidences for practitioners that engagement in any project with children who do not want to be there is difficult or impossible (DiGuiseppe et al, 1996). In this study, all young people interviewed reported a motivation to attend in order to get help, but none knew what "help" would be like. The themes of how practitioners and young people worked together developed from young people's accounts are shown in the *Figure 19* below.

Figure 19: Young people - themes of working together

Young people: working in the space	
Themes	**Subthemes**
Openness and emotions	• Talking • Expressing emotions
Power and control	• Choice
Not being judged	• Being believed • Being taken seriously
Participation	• Activities • Encouraging progress

7.3.1 Openness and emotions

Comments by young people on how they came to feel safe enough to talk to their practitioners about private things are relevant to the creation of safe spaces and demonstrate the significance of early conversations. Trust, once established, remained significant throughout the relationship, and young

people felt able to express their thoughts and emotions in ways they could not in everyday spaces: *"I could just sit down and talk to her about anything"* [Georgia, 19-20].

The theme of young people feeling able to use the space to talk about anything was common, and reflected the difficulty of having no one in their everyday spaces with whom they could talk about feelings or abuse related issues. Georgia preferred talking to other activities offered – having a relationship with someone that she could talk to about *'anything'* was important at a time when school, home and friendships were problematic. Even if she went to a session in a bad mood, she came out in a better mood. In relating significant aspects of her life in interview, Georgia described being in an unsettled transitional period in her life, finding school an exceptionally difficult place to be, and finally moving positively into a course she enjoyed. Talking meant everything from having "*a general chat about how the week's gone"* [Georgia, 145], to discussing her problems, to "*ranting":*

> *"... if I was in a bad mood I'd just rant to her for ages, and if I was in a good mood, we'd just talk about whatever really."* [Georgia, 165-167]

The significance for Anya of feeling "comfortable" with her practitioner in the early stage of their relationship was noted in Chapter 6. Openness and honesty are qualities which practitioners hope that young people will acquire in working relationships, and Anya's view of the process shows the emotional and behavioural context of her relationship and illustrates how she saw her participation in sessions changing in relation to how her worker *"acted"* with her:

> ***"****I realised the more honest with them you are, the more they can help you… cus at first I thought 'I won't tell her much, cus I don't want to be worried or like go on to that subject' but then after a while I was like, 'no, cus she'll then help me with it and it will be better, so it's better to be honest'.* [Anya, 264-268].

The underlined "direct speech" passages above highlight Anya's thoughts of how the change in relationship in terms of progressive feeling of trust in her practitioner affected how open felt she could be in sessions:

> "Y*ou know that they're there for you, they're part of your life, cus you're going there every week, and you're able to become so comfortable with them, that you can't imagine talking to anyone else but* ***[Worker]*** *about that sort of stuff, so you become so used to it*." [Anya, 354-357]

Heather also perceived her practitioner as the only person she could talk to about her abuse and about family relationships, and her favourite task was her workbook. Once she felt safe and comfortable, talking became easier. She was "*worried about sharing my past, but as I got to talk about it, it got better"* [Heather, 91-92]. Heather's descriptions of the way her worker responded to her show an experience of being valued and cared about and also of caring for another. She and her worker were "*looking out for each other*" – an extension of experiencing trust, safety and connection:

> *"...she was always there, and like when I told her about my self-harming, she was like, from a happy mood, she just went straight down into a sad mood. And then, I always made her laugh, so I always made her happy after a while. So she always used to look out for me and I always used to look out for her."* [Heather, 95-98]

Heather described her worker as "*like a friend, a sister".* Looking after each other is something that is meaningful in a friend-relationship, imbued with responsibility for the well-being of the other person, and for Heather making her worker happy was part of their relationship. As her practitioner noted, Heather's workbook was a task enjoyed with a person who was special to her. That Heather chose to be open in the research interview about her life and to share her workbook had an impact on the content and process of the interview and provided a unique opportunity to share details of how she and her practitioner worked together.

In sessions, young people discussed difficulties and also expressed emotions. Emotional responses to CSA include short-term, or "*initial"* (Finkelhor and Browne, 1986) effects of fearfulness, aggression, guilt, shame, and difficulty sleeping. Although in interviews young people were not asked to talk about feelings related to their abuse, they shared

information about their emotional expression in sessions, describing crying (Darcie, Heather), feeling anxious and fearful (Evelyn) and feeling angry (Georgia, Darcie), and having trouble sleeping (Evelyn, Georgia). Darcie's carer recalled that Darcie was "*overwhelmed"* by strong feelings, did not understand them, and was not able to talk about them with anyone. Darcie commented that she felt liked and welcomed by her worker, and thought it was "*a good sign that I felt like I could tell her quite a lot and how I was feeling"* [Darcie, 164-165]. The relationship was different to other professionals she had known:

> *"That's how relaxed I was really, that I can just be myself and just tell her quite a lot. And we did loads of things, like, we got – we have this big ball and just let out all the tension, like an exercise ball. We had the like sand pit, and some rocks and shells, and you know she just said be creative you know and say what's on my mind. And that was very emotional."* [Darcie, 40-44]

For young people to feel comfortable talking with their workers about their problems required an experience of someone listening, responding and paying attention. Darcie noted that not only did her worker listen, but she also observed her body language, which for Darcie was important as expressing herself in words was sometimes difficult:

> *"I see myself when I have deep sessions, [**Worker]** can see when I was getting like angry, you know she could tell that I was getting a fist ready, so she could see by the body language …and then she could tell that my breathing, what I was doing."* [Darcie, 97-99]

All young people said their workers were good at listening, but Evelyn gave a perceptive description of how she knew this:

> *"Because like when she asked me a question and I answered it, and she looked directly at me. And then she'd say something related to the question with my answer in it. So I knew that she was listening to my answer. And she was trying to relate other questions to my answer to like get more."* [Evelyn, 351-354]

The expressive sharing of feelings and thoughts with therapists is specifically recognised in Bordin's (1979) discussion of collaboration on tasks as he notes that although the emphasis and techniques in therapeutic

approaches vary they all "*require honesty in reporting on one's life and most of them...require self-observation of inner experience"* (Bordin, 1979:254). Whether therapy achieves this through play, art or talk, openness helps establish the nature of problems from the individual's point of view, whether adult or child. From a social constructionist perspective, sharing assists the dialogue through which meaning is constructed, whether it is a dialogue of words or actions.

7.3.2 Not being judged

Contributing to young people's feelings that they could share thoughts and emotions with practitioners was their experience of not being judged. Young people talked about the importance of being believed and taken seriously to help build and maintain trust and safety, which in turn enabled them to be open and to express emotions in sessions.

In interview, Georgia often referred to herself in the past as being "*horrible*" and said she found it hard to believe that anyone "*took me seriously"* [Georgia, 106]. However her worker did: "...*she's just nice. She doesn't judge you or anything"* [Georgia, 91]. Georgia saw her practitioner as someone who was on her side within both the therapeutic space and her everyday spaces and described her as someone who would "*fight my corner"* [Georgia, 21]. When Georgia reported that she felt able to "*rant"* at her worker, and Heather said she could talk to her worker with *"no one moaning at me"*, they were responding to their workers' communication of what Landreth terms "*caring acceptance"* (Landreth, 2002: 210), which includes not judging.

For Brenda, and for her family, being believed and taken seriously was key to working collaboratively. Professionals initially took her situation seriously but then questioned the veracity of her accounts, and such conflicting responses left the family feeling defensive and angry. Brenda liked her practitioner however, and, when asked, explained that perhaps a 'best thing'

about her was *"...just how understanding she was, she never really questioned me, that's probably the best thing"* [Brenda, 64-66]. Not questioning in this instance related to believing her, accepting her reality, and not judging her choices. Further, Brenda also valued the sense of mutual respect which grew over time: "...*probably what was most special was that we had kind of a respect as well, like she seemed to respect me [it] felt quite equal"* [Brenda, 224-226].

Evelyn, Anya, and Heather too identified non-judgmental attitudes as memorable. Evelyn, having said that working with her practitioner was "good", elaborated on her concept of 'good' as meaning *"...everything I said she didn't react as though I was lying or anything, and she understood everything I said* [Evelyn, 15-16]. Anya, describing favourite things about her worker, reported that

> *"...no matter what you wanted to talk to her about you just felt you could, like she wasn't going to like judge or like say anything back, you could just slowly talk through it."* [Anya, 80-82]

Added to Anya's comment that her worker was not "*constantly on at me"*, this passage illustrates how young people responded to practitioners who showed that they were listening with understanding and care, were taking issues that young people brought seriously, and were not judging. Heather believed that her worker took her seriously because she used to "*tell me off"* for self-harming, although this was telling off in a caring and empathetic way rather than a chastising or punitive way. Heather added that her practitioner *"thought everything was important, and she believed everything I said even if other people didn't"* [Heather, 497-498].

Although circumstances were different in each case, young people perceived that the reality they voiced in sessions was accepted, and this was important. Further, young people experienced mutual respect, which made this relationship different from many other relationships with adults. Landreth describes as the "*epitome of respect*":

> "*...to be accepted just as one is without even the possibility of criticism, evaluation, judgment, rejection, disapproval, censure, condemnation, punishment, penalty, rebuke, reprimand, praise, compliment, reward, or accolade".* (Landreth, 2002:210)

People generally desire to be believed, as to be known as dishonest or to be called a liar represents rejection, reinforces negative self-image and undermines confidence. Many children who have been sexually abused fear being disbelieved if they disclose. Their fear silences them, and contributes to any sense of worthlessness, powerlessness and helplessness that they may hold. The next section examines young people's perceptions of control and power in the therapeutic space.

7.3.3 Power and control

Power has no intrinsic value, and cannot be possessed. It is contextual and relational (Cecchin, 1992), practiced and grounded in relationships (Warner, 2009). Young people's localised perceptions of being in control and having power within the therapeutic space were represented by accounts of being encouraged to make choices and challenge. The precedent established in creating a safe relational space in which power is shared continued throughout the working relationship. All young people had something positive to say about their capacity to make choices, and the feeling of being in charge in the therapeutic space was significant for all.

The most obvious examples of choice expressed by young people were in how to work in sessions. These included decisions about what to do, for how long and to what depth, and how to communicate. Letting young people know that they could be in charge in their therapy began with the choice whether or not to attend and continued to the end, when young people decided when they had had enough. Anya expressed surprise at unexpectedly finding that nothing felt forced once she started her sessions. She described feeling "*happy"* because she "*chose to do this, and I'm comfortable with the person I'm with and everything"* [Anya, 65-66]. In

talking about who decided what happened in her sessions, Anya gave a detailed account of how choosing worked:

> *"…near the end, we would just talk about what subjects I want to look over, and like give me a choice, or like what I want to do, like she'd ask me if next week we're gonna to make something and so I was able to choose, which was quite nice cus that made it even more looking forward to it, not seeing it as a chore going there, cus that's what I thought it was going to feel like – it's not exactly, you don't want to talk about stuff. But it made it almost nice cus you were like 'Oh I chose to do this next week'."* [Anya, 124-130]

It is evident that she was able to reject her worker's suggestions in favour of her own, and to choose what she wanted to talk about. Her therapist made sure Anya's choices were informed by sharing information. When Anya was unnerved by the prospect of "trauma processing" because she did not understand what it was her worker explained, adjusting her language to suit the situation. The language of therapy for those who are not part of the therapeutic world can be alienating and exclusive, and can increase the experience of power difference. It was apparent to young people that practitioners monitored their understanding and engagement – Anya, for example, pointed out that her worker "*could tell if I wouldn't want to do that or not*" [Anya, 116] and "*started to know what I liked to do*" [Anya, 135].

Having power to choose involves being informed and young people relied on their therapists to explain process and consequences of some activities. For Brenda, 'trauma processing' involved the use of *EMDR (Eye Movement Desensitisation Reprocessing;* Adler-Tapia et al., 2012). Brenda found that having control over what she did in sessions consolidated her feelings of safety and trust as time went on. The *EMDR* presented a complex choice: the practitioner was in a privileged position in terms of knowledge and experience, and Brenda needed an explanation in order to make an informed choice about participating with the technique. Even with information, it is difficult to envision being able to understand what such a process means before trying it, so decision-making occurred in steps. Brenda described her option as a commitment to a therapeutic course

meaning that once she started, opting out became more difficult. Her worker explained to her that there were "breakthrough points" which they could identify together, and once started, she needed to "*get through it"* so her choice became simultaneously difficult but clear:

> *"She gave me a choice, and then I'd obviously say whichever I wanted to do… I chose to start EMDR, I said that I'd like to do it, she suggested it, but then towards the end it was kind of – not compulsory – but like, it was like to get through it you kind of have to carry on with it. So I wouldn't say near the end that I chose, because I probably would have stopped, even though I'm glad I didn't but yeh I'd say generally I had a choice in what I did."* [Brenda, 148-152]

Darcie felt that she had choices in working with her therapist, and was clear that if she didn't like something she could say no. Darcie described having two kinds of sessions with her worker, *"heavy"* or deep ones, which felt emotionally more demanding, and *"light"* sessions where activities felt less like work. During the interview Darcie's carer recalled:

> *"I remember **[Worker]** said, she used to say to you 'When you come in for a session it's up to you' … 'If you don't want a heavy session, if you want to have a fun session, or a light session, you just say and that's what you can have', and I remember that being quite important to you because when you felt anxious about coming you used to say 'Well I'll just tell **Worker** that I just want a light session.' You know, like 'I'll just have a nice time, we don't have to go anywhere horrible today'."* [Darcie's Carer, 260-265]

The direct speech passages marked illustrate the carer's memory of Darcie's recounting of the dialogue between her and her practitioner, and the importance of her feeling of being in control of sessions. This feeling is in direct contrast with the misuse of power in abusive relationships, and represented an important aspect of collaborative working within the relational space.

Empowerment in young people's accounts relates to choice, freedom to express and *"be"* themselves, and make decisions. They had some control over process and content and were given specific details about consent as described in the previous chapter. Their understandings of having power

were grounded in the relationship, in practitioners' behaviours which made them feel comfortable, relaxed and able to have a say in how they worked on problems.

7.3.4 Participation

The theme of participation addresses what young people said kept them attending sessions, particularly at difficult times. Research indicates that for children and young people, bond development is a *"systemic construct"* with parent and carer support for interventions associated with both progress and attendance (Jensen et al, 2010), and that parent and youth alliances are important for both ongoing participation and outcomes (Hawley and Wiesz, 2005). Young people in this study expressed motivation to attend and were supported by parents to a greater or lesser degree, but their continued participation was encouraged by the relationship they developed with practitioners.

Anya's statement about choosing what she did suggested that having choices not only represented a sense of control over the process, but also helped maintain her commitment and made her "*even more looking forward to it"*. Choosing meant that she could participate in activities she selected such as painting and drawing rather than talking. Therapeutic tasks could be made fun, including working with negative emotions which her practitioner turned into a game. Coupled with the comfort and familiarity of her relationship with her worker, the feeling of having choices in sessions contributed to Anya's continued attendance, and helped her through sessions she might otherwise have wished to avoid.

The Agency optimised the capacity to provide choice of activities, games and materials to cater for the age range of children and the variety of services provided. The room was one of the first things Evelyn noticed when she visited the centre and she described it as unlike her expectations:

> *"The room was colourful, it didn't look like I was stepping into a counsel session thing, it looked like I was stepping into a soft play –*

like it was so fun, like the colours and the play toys, stuff like that were really colourful and clean and stuff ..." [Evelyn, 28-31]

For her, a combination of welcoming environment and person made for what she perceived as a relaxed experience. The activities Evelyn engaged in were focused on creativity and play. Evelyn said her worker was *"happy, she enjoyed the things that I enjoyed, like she participated in the games I played"* [Evelyn, 68-69]. She understood, however, that playing games could also be purposeful, and talked about painting her feelings and blowing feathers to help with breathing and reduce panic, a game which she played at home with her mother. This technique helped her feel better, and contributed to her belief that her sessions were worthwhile. Evelyn's account suggests that she saw this kind of play as related to problem-solving and she found it enjoyable, as did children in Jensen et al. (2010).

Darcie placed similar emphasis on choice, and listed relief at not being rushed by her worker amongst positive aspects of her sessions. The relational dynamic of pace in working featured in Anya's and Brenda's interviews, but for Darcie especially being able to take her time relieved the pressure and *"panic"* that she often felt in social situations as her worker told her "'*It's OK, you can take your time'"* [Darcie, 73-74]. Like Evelyn, Darcie spoke of finding that techniques she learned in sessions helped her feel better, encouraged and motivated her, and that her worker's participation in activities was fun and helpful. "*Do the ball"* became shorthand for work on coping with anger and aggression, and demonstrated to Darcie that her worker was tuned into her moods. She was able to use the techniques for relaxation and stress management in her everyday spaces, and take her worker's reassurance and praise with her wherever she went.

Brenda too was explicit in her statement that her sense of control over the pace of therapy and her progress helped sustain her attendance. Of all young people, Brenda spoke most clearly about how difficult the trauma processing was. Brenda worked creatively much of the time, and interspersed activities like painting and drawing with the more intense and

focused EMDR. For Brenda, being encouraged but also able to say that she had had enough in a session was important:

> *"I think she was very encouraging, and kind of she more focused on where I'd get to and like how it would help me and yeh more like the positive, and what outcomes I'd get from it, and then also in sessions if she thought that I was … was really not happy with it, then we'd stop it and do shorter sessions of EMDR so it was kind of break it down a bit."* [Brenda, 175-179]

In retrospect, Brenda perceived that her progress, reassurance and hope for the future were key to her continuing. The EMDR work was hard, and Brenda found that this affected her motivation because, although she knew she was not forced to continue she occasionally felt pressured. Brenda's sense of progress and her worker's encouragement kept her going.

Heather, finally, presented a clear account of why she continued to go. Choice was important as she enjoyed her workbook, liked keeping it as a record of activities, and looked forward to talking to her practitioner. Heather did not describe any difficult times, and chose to return to see her worker as a second referral, and then decided when she had had enough. Her motivation to attend included her worker being like one of her "*best friends",* and finding she could talk about anything through the media of the workbook, art projects, and games. Heather's worker seemed extra flexible, organising longer sessions when required, recognising that Heather arrived at whatever time someone could bring her, and driving her home at the end of sessions. Heather reported experiencing progress, particularly in solving dilemmas in her everyday life during the intervention, but what was important to her and helped maintain her participation was the sense of connection with her worker.

7.3.5 Discussion

Gergen (2006) notes:

> "*If we follow the collaborative logic, therapy represents a conversation in which participants borrow heavily from their relations outside, but in*

> *which they simultaneously create the grounds for a new and unique reality (discourse patterns shared by them alone)."* (Gergen, 2006:52)

This passage refers to 'actionability', that is how people take what transpires within the relationship to the outside, what Gergen calls the "*life world"* and this thesis refers to as "*everyday spaces".* The therapeutic space and everyday spaces are separate but interlinked. This pattern is shown here in how young people brought strengths and also issues from their everyday spaces into the relational space with their workers, learned practical things that had an early impact (like breathing exercises and stress management techniques) and took them away to share with parents and/or use themselves. Their "conversations" incorporated play and creativity as well as talk, and the "work" in the sessions varied from case to case.

Each young person's account notes conversations and actions with practitioners held within a relational space where confidentiality and trust continued to have meaning which translated into action in other spaces. The acceptance and trust extended beyond the physical dimensions of the therapeutic space, for Heather in the car and for Georgia in her school and the café where they occasionally met. The experience of being listened to and believed was reinforcing and helped young people attribute blame for what happened differently (Arias and Johnson, 2013). This finding is consistent with Nelson-Gardell (2001) who cites being believed as helpful in children's views as the main finding in her research. Nelson-Gardell relates her findings specifically to the therapeutic relationship:

> *"If the trauma of abuse is to be dealt with in treatment, the therapy has to be based on a genuine and authentic relationship that relies on the formation of trust between client and clinician. Therapeutic alliance forms the bedrock of the treatment process….Believing what people say provides a validation of their experiences. Human beings need validation."* (Nelson-Gardell, 2001:412)

A child's social and emotional interactions with a therapist are unlike interactions with most other adults. Children bring to their sessions issues related to power, dependence, conflicts and attachments in family

relationships but the therapeutic relationship develops distinct and unique meaning. Communications in the therapeutic space therefore also develop their own patterns. The mutual understanding young people reported may be viewed as a form of coordinated action (Gergen, 2009) through which meaning is achieved: "*...we may say that we understand each other when we* effectively coordinate our actions – *drawing from traditions in ways that are mutually satisfactory"* (Gergen, 2009:111, emphasis in original). To make the therapeutic space special and different required therapists to present themselves as people who could provide whatever each young person required in order to participate in dialogues to help them move forward. If young people could experience their therapist as empathetic, there was a dialogue going on. Cattanach (2002) points out the constructed and unique nature of meaning in the therapeutic space:

> ***"****The encounters between clients and therapist are co-constructions. The child plays, and tells stories about the play and the therapist listens, perhaps asks questions to clarify meaning, and contextualises the story around the social circumstances which exist for that child in their world."* (Cattanach, 2002:7)

Practitioners were perceived as good listeners. Evelyn's description of how she knew her worker was listening suggests the responsive techniques of active listening and reflection. Gergen (2009) suggests that people develop familiar rhythms of interactions and conversation. He describes the most important form of coordinated action as "*co-reflecting"* and visualises participants in dialogues as mirrors which reflect, carrying "*elements or fragments of what the other has said"* (Gergen, 2009:124) when turned towards each other. Evelyn said she knew her worker was listening because she was looking at her, and when she responded she asked a question that proved she'd been listening because the question contained the elements of what Evelyn had said. She could "locate" herself in the worker's response. Gergen (2009) says that this locating self in the other's response brings the individuals closer together, thus strengthening the bond.

Listening may be conceived as part of validating the experiences of others, of "*affirmation of listening"* (Gergen, 2009: 123) in encouraging people to tell their stories, and thus part also of the act of not judging. Affirmation, which may be viewed as akin to Nelson-Gardell's (2001) notion of validation, serves to *"honour the validity of my experience"* (Gergen, 2009:123) whereas to challenge, or disbelieve, not only discredits one's realities, it also discredits the *"relationships from which they derive"* (Gergen, 2009:123). Young people saw their workers as non-judgmental and believing, which was important for those who experienced emotional impacts of shame and guilt. Shame in children experiencing sexual abuse arises in the context of secrecy, helplessness and adult disbelief and blame (Summit, 1983). Emotions of shame and guilt are associated with Finkelhor and Browne's "*dynamic of stigmatization"* (Finklehor and Browne, 1985) as they are contextualised in the perceived negative responses of others to the child's abuse. Guilt and shame may also be related to disclosures of abuse, and therefore may be confounded with emotions stemming from the abuse experiences themselves. Shame has been identified in literature as common particularly among victims of sexual assault in comparison with other crimes (Weiss, 2010). Weiss identified categories of "shame narratives" from the literature comprising "*self-blame, humiliation and fear of public scrutiny"* (Weiss, 2010:292). In this study, young people were not asked to talk about any aspect of their abuse experiences, and comments related to shame and guilt are less explicit than those extracted from survey responses in Weiss's study, and are derived through interpretation. However, from young people's, parents', and practitioners' interviews underlying stories consistent with the "shame narrative" categories appear, and include embarrassment, and fear of others knowing, of disbelief and of blame.

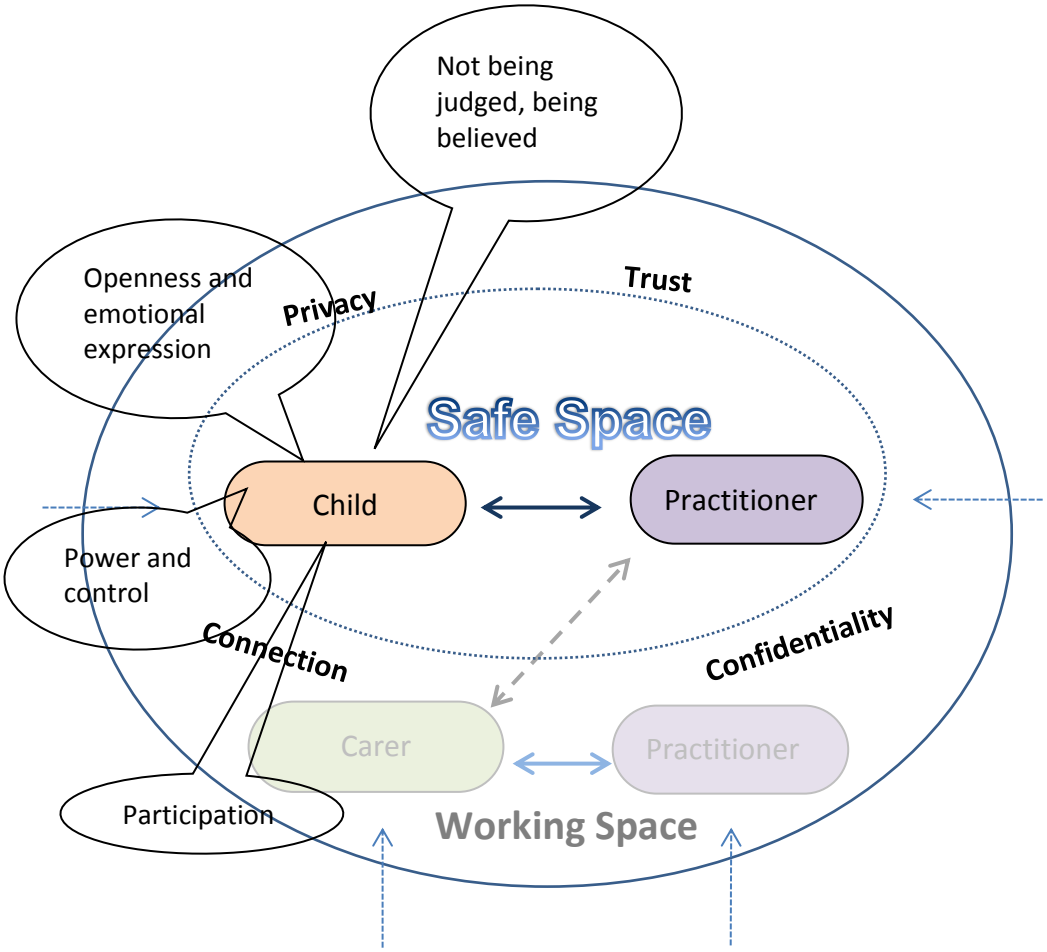
Summit's words about power and permission, although about disclosure, are relevant here – the powerlessness experienced by children in the act of abuse (unethical behaviour) may be restored in the act of healing, in this case through relationship in therapy:

"Unless the victim can find some permission and power to share the secret and unless there is the possibility of an engaging, non-punitive response to disclosure, the child is likely to spend a lifetime in what comes to be a self-imposed exile from intimacy, trust and self-validation." (Summit, 1983: 182)

7.3.6 Summary

Young people described collaborative working in various ways in the safety of a therapeutic space where they felt they could be open, had choices, were believed and not judged, and found encouragement. These themes are illustrated in *Figure 20*:

Figure 20: young people, working in the safe space model



The arrows pointing into the circles represent what participants bring to the therapeutic space from outside, and the speech bubbles the themes

developed in analysis relationships inside the safe space. The next section examines practitioner views on working with young people in the therapeutic space.

7.4 Practitioner perspectives – working with young people

This section presents practitioner perspectives on working with young people. The themes follow the pattern of themes from young people's perspectives: enabling openness and emotional expression, not judging, power and equality in the relationship, and maintaining participation. Within the theme of participation, practitioners talked about skills, using techniques, and applying their knowledge.

Figure 21: Young people's practitioners - themes of working together

Young people's practitioners: working in the space	
Themes	**Subthemes**
Enabling openness and emotional expression	• Working at an emotional level • Communication and rapport
Sharing power, relinquishing control	• Providing choice • Restoring sense of power
Being non-judgmental	• Prioritising young people's reality • Taking it seriously
Participation	• Trying things out • Fun and laughter • Noting progress • Using knowledge, skills and expertise

7.4.1 Working with openness and emotions

In their interviews, young people described a process of becoming more open with their workers, sharing details about their lives that they could not share with others including their parents, and feeling free to show their emotions and "be themselves". Practitioner interviews revealed how they

encouraged this process using their skills in communication and rapport, their experience and knowledge, and the techniques they had at their disposal. Practitioners, despite different therapeutic backgrounds, agreed that working effectively with trauma involved working at an emotional level. As Brenda's therapist pointed out,

> *"I think cognitive stuff is all very well, but if the emotional stuff's not kicking in, then it has limited effect, and this is how I felt the work was… my sense was she wasn't feeling it."* [Brenda's worker, 22-25]

Workers noted that young people varied in their ability to talk openly and express emotions. Chelsey's and Evelyn's practitioners, for example, portrayed them as able to do this early in the relationship. Brenda and Anya, on the other hand, appeared more reticent and it took some time before their workers felt that they were comfortable enough to share their feelings. Research with sexually abused young people confirms that although opening up about what happened and "*getting their feelings out"* are difficult, it helps (Nelson-Gardell, 2001:408). However, as the practitioners in this study recognised, it was neither appropriate nor possible to rush young people. It was, however, possible to encourage them once they began to feel safe.

Georgia's worker found that Georgia "*really developed a trusting relationship in me and was able to talk to me about quite personal things"* [Georgia's worker, 14-15] although it took some time to build what was perceived as a safe relationship. Her statement is consistent with Georgia's view that she could talk to her worker about anything. The practitioner commented about the impact of their work to improve Georgia's presenting symptoms on the strength of their relationship and on Georgia's openness. The process of together solving problems which had a tangible effect on Georgia's everyday life helped strengthen the bond in this case and ease the way for Georgia's continued engagement, as opening quote of the chapter suggests.

The worker's insight into the link between their work and their relationship recalls Shirk's and Saiz's (1992) concept of the association between bond

and collaborative action in creating and working in the therapeutic space. The same practitioner worked with Heather and found that she too was able to talk about anything on her mind, including difficult issues. The worker attributed this to the safety that Heather felt in the relationship, noting that Heather brought:

> *"…quite personal things that weren't initiated by me... she'd talk about them and she obviously felt safe and comfortable doing that. Just being herself really."* [Heather's worker, 14-16]

As Anya noted in her interview, talking became increasingly comfortable and she believed that being open and honest would help her worker to help her. Her words are notably similar to her practitioner's account of her message to Anya, encouraging her to be open and honest:

> *"It's about being able to say that 'I will be with you, I will help you through this, I will support you with this. And you have to be able to tell me when things aren't OK for you, and be honest with me, so, I can't help you if I don't know.'"* [Anya's worker, 250-252]

Anya's worker assessed that loss, shame, and anger were significant emotions for her, but that she had not opportunity to express them. As she said, young people often "*suppress the anger because it is frightening to them"* and added that getting angry and shouting "*wasn't what nice girls did"* [Anya's worker, 182-184]. She devised an activity which she called "*target practice"* to help Anya express her anger in a humorous but effective way. Interestingly, Anya's account of experiencing the therapeutic space as a place where she could "*be myself*" concurs with the worker's view that what would help would be the opportunity for Anya to express rather than hide her feelings. Other practitioners devised various activities and games for young people which provided opportunities to engage together in encouraging emotional expression such as Darcie's ball, Georgia's volcano, Brenda's art, and Heather's work book.

7.4.2 Not judging

Young people recounted the importance of being believed, being taken seriously, being listened to, being understood without feeling silly, blamed, or

judged. Their practitioners' accounts provided evidence of non-judgmental values and practice. Practitioners in their interviews talked about believing young people and accepting their versions of reality (Brenda's worker), respecting their decisions (Heather's worker), understanding without judging (Anya's worker), and holding a position of "*unconditional positive regard"* (Darcie's worker). These values are also reflected in practitioners' expressions of warmth, friendship and genuine affection for young people. As Darcie's worker said "*we really, really liked each other and held each other in high esteem"* [Darcie's worker, 150-151].

Georgia's description of her therapist as someone who would "*fight my corner"* evokes images of an advocate, someone prepared to speak up on her behalf and to act in her interest. Her worker's account coincides with Georgia's as she noted that they "*got on really well"* and she believed that Georgia:

> *"...felt that I was on her side really and that hopefully that I was listening to what she was saying … and then trying to do something about it rather than just sort of saying 'Ok, you feel like that, right Ok', we were trying to kind of move things on for her really."* [Georgia's worker, 97-100]

This was acceptance followed by action. Georgia's practitioner was transparent in her partnership with Georgia's mother as "*we*" in the quote above referred to actions initiated by the worker with Georgia's agreement, and agreed and continued by her mother. She felt that much of their work was about resolving emotions, and saw her role as that of another safe adult who could encourage and support, but who neither judged nor chastised and was not emotionally involved. The effect of collaborative working including a supportive parent affected, in the worker's view, both the therapeutic relationship and potentially the mother-daughter relationship.

Anya's worker described providing a relationship in which young people could talk freely and feel they were listened to and understood. She viewed her role as a safe and independent adult. The following quote occurred in a

discussion about whether the practitioner thought it would be possible to achieve the same level of therapeutic change in a different relational context:

> *"I think because the therapeutic relationship is a unique relationship, because you're not a parent, you're not a teacher... it is a different relationship… and it's a place where you come to deal purely and simply with this particular issue. You don't have to deal with it anywhere else ... this is the one place where you can talk about it freely, where the person you are sitting and talking to gets it [emphasis], isn't there to judge you, is there to help you and support you, hasn't got another agenda, do you know what I mean, so the idea is that this what we're here for, to work with this."* [Anya's worker, 433-441]

Brenda's experience of being judged had, in her therapist's view, been particularly damaging, so it was important for her to separate herself from other professionals, and infuse the therapeutic relationship with belief in Brenda's story. Gaining mutual understanding of this avoidance of judgment and criticism represented a significant point in their relationship:

> *"I think she felt very judged... it was the thing about being called a liar, I think – I don't think anybody used that word, but the implication was definitely there. And it was a turning point, and I think* ***[Brenda]*** *felt like I stuck by her … and she just went from strength to strength."* [Brenda's worker, 111-115]

7.4.3 Sharing power and control

> *"I hope for her that felt like 'I am able to set the agenda here and I am able to like do what I want to do when I come, and if that's to focus on my abuse that's fine, but also if it's my friendships, and falling out, and how I feel about that then that's what I want to share with* ***[Worker],*** *and she'll hear that'".* [Chelsey's worker, 371-375]

In their reports, young people indicated that they valued choice and control over how they worked in sessions, and saw qualities in their relationships with practitioners, such as friendship and sharing, that represented a sense of relational equality and reciprocity. Young people's practitioners also emphasised sharing power and control in the relationship with young people. The agency context required boundaries and workable routines, but within

the relationships practitioners worked towards helping young people feel, as the quote above suggests, in charge.

Frances's worker ensured Frances felt empowered to talk about anything she wanted or choose not to talk at all. She left silences, maintained the routine and the space but did not impose her choices or expectations. She respected Frances's decision not to be open, but also found her reticence awkward. Having no information from a young person can be difficult for professionals. She did not know what was holding Frances back, but her response to a young person who may feel blamed for what happened and for disclosing was to be, in the relationship, accepting and non-judging.

Faced with a less responsive young person, practitioners may also doubt their own skills and feel inadequate and ineffective, as Frances's worker noted in characterising their relationship as tentative:

> *"I think maybe tentative …and not in a negative way, I think just that was how it felt, it felt quite, yeh, I think she was quite tentative, and I think I was to a certain extent, especially in the beginning, cus I was a bit unsure of what to do. She was quite a challenge, not because she had any challenging behaviour … but for me as a worker it was a challenge because I think usually I feel I'm quite good at engaging young people and kind of being able to develop rapport, and I just thought you know 'Phew – is it me, is it something I'm doing...'"*
> [Frances's worker, 239-245]

Evidence that practitioners sought to increase young people's sense of power in the relationship is found in numerous references to choice-giving and respect for young people's knowledge of their experiences and their world, that is, their "*local knowledge"* (Parton and O'Byrne, 2000:184). Therapists regularly had plans or activities set out but were client-led and abandoned them in favour of the young person's needs and wishes. Anya's worker rarely planned too far ahead:

> *"I don't tend to plan things too much in advance, but I tend to see whatever's there and say, 'Right, how do you want to work with this? What shall we do with this?' Cus there'll be things that come up which are significant for them, and I think that's, for me it's about being able*

to find out what it is that's happened for that child currently." [Anya's worker, 79-83]

Darcie's worker described her understanding that Darcie knew how she felt each day, how prepared she was to undertake therapeutic tasks, and how important trust in the relationship was to her participation:

> *"I think if she hadn't have had the relationship, she wouldn't have talked about what happened, and we were able to do some really quite deep work, because she was able to trust in the relationship … and I was able to be honest with her and really talk to her and say, look, 'If you feel like it's a bad day for you and you don't want to do this deep work, then you say that, and if you feel like 'Yes, you can push me a bit today even though I don't really want to do it but I do' so I sort of tried to give her the choice, and sometimes she'd say 'Oh I don't want to do it* ***[Worker]*** *but let's just do it now'".* [Darcie's worker, 71-78]

The 'direct speech' underlined in this passage represents the kind of dialogues she and Darcie had about Darcie being in charge of the pace and content of sessions. Darcie's practitioner noted that sometimes Darcie just wanted to talk, and the worker felt a need to balance providing choices and allowing Darcie to just talk with what she viewed as a therapeutic need for Darcie to be in touch with her feelings. Although Darcie was the expert on her life, the worker was the expert in therapy and had the knowledge to achieve change:

> *"I felt by talking she was able to avoid a lot of the feelings, so I explained that to her, and I said 'You know and I know it's difficult, but we can get some of the feelings out, you may notice a difference.' ... sometimes I'd say 'Well I know you'd rather talk, but I'm thinking there might be some stuff left that we could get to if we did this, what d'you think', and then sometimes she'd say 'No I don't want to do it today' and then sometimes she'd say 'Right, let's have a go'. So she did, she did try it to be fair, but that was my suggestion."* [Darcie's worker, 92-96; 102-106]

The practitioner was still leaving Darcie with ultimate control and the right to decline, but helped her make her decision by providing information so that her choice was informed, much as Brenda's worker did when introducing her

to *EMDR.* Anya's worker also noted that young people are sometimes compliant and that workers have a responsibility to ensure that goals remain part of the therapeutic dialogue by reminding them why they are there. However, at other times the "*just talking"* is equally important. Chelsey's worker pointed out that therapeutic progress does not happen at all the time, and sometimes simply being in the relationship, as the child sees it on the day, is equally valid. There was a part of Chelsey, she noted, that just *"wanted to come play with dolls"*. So sometimes

> "...*it felt just like play, it just felt like 'Oh, she's brought her doll in today, and we're just – I'm her friend and we're both playing with dolls'"* [Chelsey's worker, 193-195].

7.4.4 Participation

Young people described how they participated in the relationship in various ways through play, talking, and activities. They also noted the importance of progress – feeling better and solving problems helped cement the relationship. A sense of routine and familiarity and comfort helped ease some of the more difficult therapeutic tasks. Practitioner reports confirmed young people's accounts that the amount of time it took to feel at ease talking about problems varied. Frances became more "*talkative*" in time. As she was not interviewed, it is possible only to surmise that her worker's patience, use of silence and reflection might have helped Frances feel she could open up. Although her practitioner felt that they perhaps only touched the surface of issues, once she began to talk, the worker felt her engagement, "*reserved"* as it seemed, was maintained until they finished. Their relationship had changed, and Frances' worker reported that the turning point was so unusual and sudden that she remembered it clearly:

> "*There was one session, I remember it vividly, where actually she initiated conversation with me and it was about, she told me she'd got a boyfriend, and it was about him, and it was about how different he was from her previous boyfriend, and she initiated all of that conversation and I was kind of astounded really I was so thrilled*

> *[laughing] that she'd felt that she could kind of just come to this session and talk about him."* [Frances' worker, 31-36]

Therapists described "*wobbles*", "*blips"* and "*bumps*" in their relationships which threatened participation in therapy. These were moments in the relationships where an event, reaction, or difficulty threatened the stability of the relational process. Such moments may represent ruptures in alliance, "*signalling a critical point in the therapeutic process"* (Friedlander, 2015:174). They may be minor fluctuations in the relationship which have insignificant consequences on working together, or they may be major enough to risk the relationship and terminate the therapy.

Brenda's worker, for example, felt their relationship was threatened by a second disclosure and the resulting stress on family relationships with professionals, an occurrence which she described as an "*interesting bump*". The practitioner called upon her reflective skills and her values and made a professional decision to be there for Brenda and distance herself from investigative processes, stepping back and providing a space for Brenda to express herself. The importance of context around the relationship is clear in this case. The chronology of events in everyday spaces affected the path of the therapeutic relationship. This underscores how social relationships do not occur in vacuums and are interrelated.

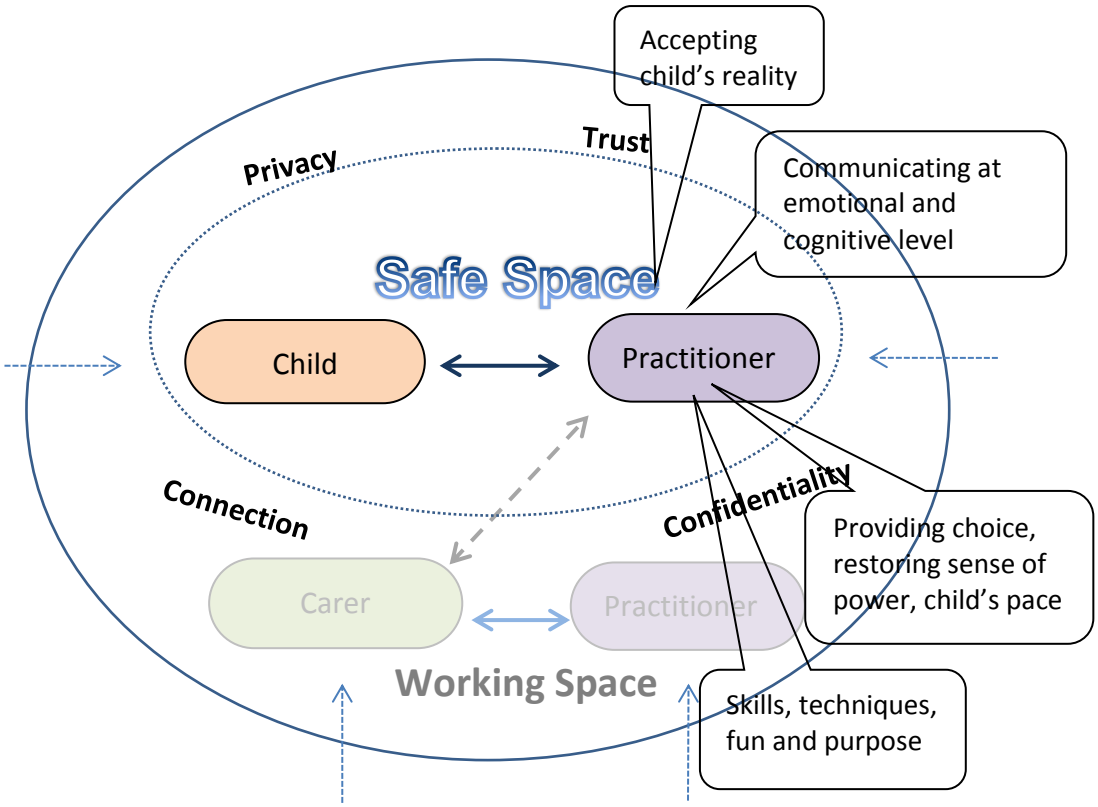
Darcie's worker felt that sometimes Darcie was "*a bit cross with her*", but these minor bumps did not affect their overall relationship. Chelsey's "wobble", unexpected by her therapist, occurred in the context of a joint session. The practitioner resolved the situation to ensure Chelsey's continued engagement, and considered what it told her about Chelsey and her situation in the family, which in turn provided an additional therapeutic focus. Anya's worker identified Anya's fear of "trauma processing" as causing her to be "*a bit wobbled*" but resolved the anxiety by explaining what it meant in practice and reinforcing Anya's power of choice. Practitioners worked hard to maintain young people's engagement with the process, and young people noted that feeling better encouraged them to continue. When

practitioners were concerned either about the therapeutic relationship or about therapeutic progress, they found support and encouragement in colleagues and supervision. When they observed positive change within sessions or through external validation, they also felt encouraged. Validation becomes part of the relationship and change dialogue, as illustrated by Anya's worker's statement:

> *"So that was really helpful for me when mum and dad basically said that they'd seen changes in her, and you know, they'd seen that she was loads better, she was more positive and more powerful in herself. That was something I was pleased with."* [Anya's worker, 602-605]

Figure 22 illustrates the themes developed in the practitioner accounts of working with young people:

Figure 22: Practitioners - working with young people in the safe space



7.4.5 Discussion

Practitioners shared, from different perspectives, the idea of harm represented as traumatic impact, and faith in therapeutic interventions to help children recover. Their accounts also demonstrate their understanding that considering control and choice as qualities of the relationship mattered. In a relational context in which social differences in age, experience and status mediate against equality, practitioners demonstrated values of empowerment and respect, and skills in reflection, understanding, and child-focused practice. Workers had an investment in encouraging participation in young people, representing the idea of "*contingency beliefs"* (Shirk and Saiz, 1992:724) as mediating children's engagement in a problem-solving process. By understanding how young people viewed their problems rather than accepting how other people defined them therapists might be more likely to gain trust and confidence and collaboration. Young people who felt they could be "*honest and open"* (Anya), complete a programme of EMDR (Brenda) or embrace breathing techniques (Darcie and Evelyn) demonstrated in their actions an understanding of their investment in the therapeutic process and confidence in their practitioners.

Practitioners drew on a wealth of knowledge, skills, and experience to help young people participate, but at the young person's pace. They recognised that addressing trauma prematurely, before young people were "*stabilised within the therapy*" (Lefevre, 2004:139) and comfortable within the relationship, was unlikely to succeed. Practitioner accounts referred to training, different therapeutic approaches, skills, personal qualities, and a variety of techniques used with young people to encourage participation, according to age and individual needs and circumstances of the child. All the relationships involved communication and conversation. Anderson and Goolishian (1992) describe the therapist's role as:

> "...*that of a conversational artist…whose expertise is in the arena of creating a space for and facilitating a dialogical conversation…The therapist is a participant-observer and a participant facilitator of the therapeutic conversation"* (Anderson and Goolishian, 1992:27).

Practitioner accounts reflect the idea of the therapist role as both participant and facilitator. As participants they joined in the tasks, games and conversations with young people; as facilitators they remained focused on the therapeutic purpose, using skills, techniques and knowledge. As individuals, they prioritised the accounts which young people brought to the relationship. The multiple and interconnected facets of the therapeutic relationship presented in practitioners' accounts are compatible with Gaston's (1990) view of the therapeutic alliance as *"multidimensional"* (Crits-Christoph and Connelly, 1999:688) and encompassing purpose, connection, and "*empathic understanding and involvement"* (Gaston, 1990:145; Crits-Christoph and Connelly, 1999). The other dimension, agreement on goals, is discussed more fully in Chapters 8 and 9.

Practitioner accounts, like young people's, emphasised the value in the relationship of providing choice and privileging young people's stories. There is a relationship between themes of not judging and power sharing. Power, Cecchin (1992) wrote:

> "*… is an idea, a construction. People create the idea of power and then behave as if power existed. Power is created by the context and is invented by the protagonists of the situation."* (Cecchin, 1992:88-89)

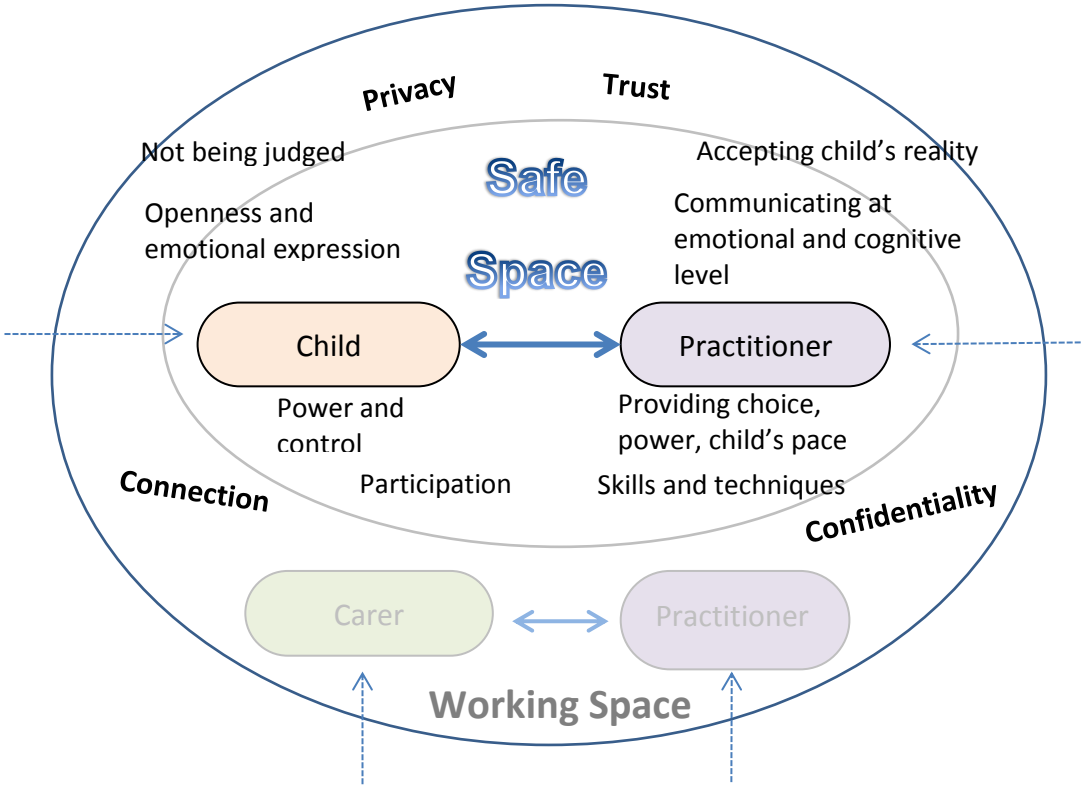
This concept involves seeing people as engaged with one another to make sense of their relationships, and understanding negotiation of power as one of several ways of making sense. In therapy, this way of thinking calls upon therapists to relinquish their self-identities as experts and to accept multiple realities, without judgment on whether one is "better" than another. Acceptance of multiple realities in practice can cause dilemmas where, for example, workers strive to adhere to ideals of empowerment and non-judgment while simultaneously pursuing social and political agendas of the agencies for which they work. It is a dilemma represented in this study with honesty and transparency by Brenda's practitioner in her references to her decision to "*step back"* and take her lead from Brenda. She recognised that Brenda, as a young person in an exploitative relationship, had a different

view of her choices and her situation, and could not be forced to accept the view of others, including her therapist. Changing her view of the relationship in which she had been involved required time and a space in which she could contemplate other choices and solutions.

7.4.6 Summary

Practitioner accounts of how they developed ways to work together and the kinds of activities or conversation they felt worked well for young people were compatible with young people's stories. They agreed on how to work in the therapeutic space they created. Because their accounts are inextricably interconnected and recalled rather than observed, it is impossible to comment on patterns of communication and who responded to whom. Recollections of relationships are constructed, and influenced by other conversations with, for example, colleagues and parents. Gergen refers to meaning-making in relationships as "*a dance in which we harmoniously move together"* Gergen, 2009:124). *Figure 23* below illustrates the symmetry of young people's and practitioners views on working together.

Figure 23: Working together - young people and practitioners



7.5 Parent perspectives

> *"What I was coming for really helped, it weren't just to come here and have a cup of tea and talk, you know, but I were getting some kind of use from the sessions. I didn't feel I were wasting my time or anything."* [Chelsey's mother, 321-323]

As explained in the previous chapter, the relational spaces which parents developed in their own service varied in interesting ways. The sections below explore how parents worked in the spaces they and their workers created. Like young people, parents were not sure what to expect from their workers, and part of the work involved decisions about how to use the time available. Although not a therapeutic service, two similar themes of openness/emotional expression and not being judged were developed in parent perspectives.

Figure 24: Parents - themes on working together

Parents: working together	
Themes	**Subthemes**
Openness and emotions	• talking • expressing emotions • being listened to
Not being judged	• guilt and shame; "*bad"* mothers • being taken seriously • reassurance • less isolated

7.5.1 Openness and emotions

Parents, like young people, variously expressed a need for space and safety to express themselves. Anya's parents saw their practitioner together, with the exception of one appointment for her mother only, and stated that they were open about their concerns and issues from the beginning. There were, however, some individual differences in their accounts of how they worked together. Anya's father acknowledged that ***"****It was good to have someone to talk to, it was nice"* [Anya's father, 45]. He commented that their worker was good at listening and listened a lot, asked good questions, was available as a "*sounding board"* and as somebody "*independent"* to talk to, *"to get things off our chest"* [Anya's father, 108]. He described their worker as being there "*emotionally"* but did not feel he needed additional emotional support. Unlike Anya's mother, Anya's father confided in no one outside the family. He had no supportive colleagues with whom he could share, an absence which concurs with Trotter's (1998) finding related to her male participant. Anya's mother listed therapist qualities such as being there to listen, picking up on things they said, asking helpful questions. She found her individual session reassuring and focused on "*letting go":*

> *"...for me that was … obviously* ***[Anya's father]*** *had said to me before you know,* ***'****you don't have to think about it all the time, you don't have to beat yourself up about it all the time, you don't have to, you know, be like that all the time', but I think hearing it from somebody else that*

> *you're discussing it with, someone who wasn't involved in the family, it was good for someone else to say 'that's OK that you feel like that, but you don't have to feel like that all the time', so for me that was really beneficial and for you [to Anya's father] as well, just talk."* [Anya's mother, 38-44]

This passage demonstrates the importance for her of being able to open up to a professional, someone able to help parents resolve negative feelings associated with their child's abuse. Although Anya's mother had supportive colleagues and partner, she appreciated expressing her feelings to someone independent in whom she had confidence and trust.

Other parents also emphasised the value of the opportunity to express themselves openly. Chelsey's mother felt that she had permission to "*get upset".* Because she felt comfortable with her practitioner, she felt she did not have to be brave, and could show how she was struggling. Chelsey's father had been offered sessions but chose not to attend. He was not interviewed so could not express his views, but Chelsey's mother said he found their situation too hard to talk about. Chelsey's mother, on the other hand, described "*bottling everything up*" until her sessions, saving thoughts, emotions and events in her everyday life to share with her worker:

> *"Because I knew I were gonna, I'd been bottling everything up what I wanted to say, and kind of like* ***Worker*** *got it all [smiles] or I needed to, and I used to write it all down and I used to come and say, 'Ooh' and ask her this and, you know."* [Chelsey's mother, 149-152]

Evelyn's mother made similar comments, saying:

> *"...a lot of people are saying I'm very strong and independent and things, but when you're in that room for an hour you don't have to be."* [Evelyn's mother, 176-177]

Parents often control their emotions at home to preserve a sense of normality and routine for family in times of crisis, so value having a space where they feel allowed to focus on themselves, or to "be myself" to use Anya's phrase, with someone who understands. Brenda's mother described the space to talk as a couple and express their own feelings about how

devastating the experience had been for them was just what they wanted at the time:

> *"It's very strange isn't it that in everyday life, you don't necessarily sit down and talk, so it took that separate space to do that."* [Brenda's mother, 239-240]

7.5.2 Not being judged

> "'*This is your fault mum, you left me there.*'" [Georgia's mother, 202]

The importance of experiencing a non-judgmental relationship was, for parents, illustrated most vividly by references to feelings of guilt and an undercurrent of shame associated with feeling like "bad" mothers. Anya's mother spoke of constantly feeling that she "*beat herself up*", a reference to feeling distressed about her daughter's abuse, about not seeing the signs, about knowing and trusting her abuser, and about finding it difficult to know how to relate to Anya. CSA alters the relationships and dynamics in families even if it is perpetrated by an outsider. Georgia's mother, like others, was reminded of her feelings of guilt by her daughter's emotional distress and concerning behaviour. As a single parent, she was holding the family together and felt alone with her own distress:

> *"I felt really alone at the time, I felt, I just felt, I never went out anywhere, I was just working, and coming home and being here for Georgia, I felt, she still is, everything's about Georgia."* [Georgia's mother, 305-307]

She had confidence in her worker's knowledge and experience, and when asked how she felt talking to him, replied:

> *"Very comfortable. He was non-judgmental, I mean, it's a big thing isn't it – your daughter has been sexually abused by her father and [you have] a conversation with the worker about it, it's heavy stuff … but yet it just felt easy to talk about, I don't mean easy, I didn't, it wasn't easy, but it felt, I didn't feel uncomfortable because of him."* [Georgia's mother, 354-357]

It was Evelyn's mother who talked most openly about her feelings and how her practitioner helped. Although she knew that she had not hurt her daughter, she described feeling guilty and responsible since Evelyn's disclosure, and noted the consequential toll on her physical and mental health. Her guilt and fear that harm would come to her daughter made her, in her eyes, over-protective: *"I wouldn't want her out of my sight and I said to* ***[Worker]*** *it's stifling for her, it's not fair, it's clearly unhealthy*" [Evelyn's mother, 139-140]. She had not realised how debilitating or strong her responses were:

> *"I never thought I would get over how strong I was feeling about it. Because being a family member's partner, the whole family gets torn apart, and there's a lot of different things that sort of branch out from this one thing happening, but it was that one thing that I was stuck with, the guilt –I just didn't think that would ever go away."* [Evelyn's mother, 90-94]

In her account, Evelyn's mother was honest about the range of emotions she felt at the time of Evelyn's disclosure and in the ensuing years. The feeling of shame which accompanied her guilt was implied, not stated. Kavner and McNab (2005) note that whilst often linked, guilt and shame are not the same things:

> *"Guilt allows the possibility to make amends – 'I made a mistake' – whereas shame arises from the consideration of how our behaviours reflect on ourselves – 'I am a mistake.'"* (Kavner and McNab, 2005: 142-143, citing Karan, 1992: 48)

Following this reasoning, mothers who see themselves as having acted in error incur guilt; those who additionally see themselves as 'bad' feel shame.

Like other parents, Evelyn's mother's friends and family knew what had happened, but she was unable to talk to them and felt isolated. As she said, her entire world changed, as if it had come to "*a standstill".* With her worker, however, she felt comfortable and reassured by the understanding that she was not being judged. In discussing how important this was, Evelyn's mother

described understanding that people she knew were unlikely to say to her face that she was a bad mother, but that is how she saw herself:

> *"We were very open. But she just made you feel that you could be, cus there was no judging. I think that was one of the big things, and you have to say 'Well it's tough' you just have to take it, cus when you're beating yourself up about it anyway, I think that's why I was expecting that comment – but it completely changed my views… I was expecting the opposite! [laughs] I don't know why, because of course people aren't just going to say 'I can't believe you did this!' but in my mind it was like that's how I felt about myself …"* [Evelyn's mother, 147-156]

Participating mothers valued the experience of being accepted in an uncritical way by practitioners, and also the understanding they gained from their workers explaining that their reactions were common. The "normalising" process helped parents feel less isolated and alone in their emotional responses to their children's abuse. Georgia's mother, who had professional knowledge of the family impacts of child sexual abuse and described herself as resilient and resourceful, was nevertheless reassured that her experiences were common and her parenting sound:

> *"I'm not saying I know everything, I don't, but I found* ***[my worker]*** *more as a – sometimes I'd think, 'God, am I doing the right thing?' especially in the dark moments when everything had just gone pear shaped, and I'd go in and speak to* ***[Worker]*** *and he'd go 'No, no, no, that's just spot on, that's spot on, keep going with that'. But he was almost like, he was what I needed to keep me, to reinforce that what I was doing was the right thing… He was a very knowledgeable man, very knowledgeable. Very easy to talk to, very respectful, warm, and you knew he knew what he was talking about, which made me feel confident. That's important."* [Georgia's mother, 284-288; 343-345]

7.5.3 Discussion

Child sexual abuse poses particular dilemmas in prevention and punishment systems. On the one hand society views CSA as abhorrent and abusers as deserving of harsh punishment; on the other hand the nature of sexual abuse as secretive and private makes discovery, investigation, and

prosecution of offenders problematic. The role of non-abusing parents in intrafamilial abuse is complex, and impacts upon parents of sexually abused children are often difficult to assess or ignored (Jones and Ramchandani, 1999). Research on non-abusing parents is sparse compared to studies of survivors and abusers, but has described findings which resonate with themes expressed by parents in this study. The impact of children's sexual abuse disclosures, as Hill (2001:386) notes "*represents a fundamental crisis for women that threatens to be overwhelming and which has seriously disruptive long-term effects."*

Study of impacts of child sexual abuse on parents has recognised that parents experience symptoms related to secondary traumatization (Manion et al, 1996) and loss and bereavement (Erooga and Masson, 1987), and describe powerful emotional responses (Clevenger, 2015). At the same time CSA is a taboo discussion in everyday social settings, and anecdotally professionals and parents recognise that often there is nowhere to take concerns. Plummer and Easton (2007) described mothers' experiences of not being believed, of feeling judged, of being instructed on how to parent their child, of being told that nothing could be done. On a positive note, Plummer and Easton (2007) noted that mothers could identify helpful professionals, particularly the child therapists, and that the advice they would give mothers in similar circumstances was to get help for both their child and themselves.

Writers have adopted different frameworks to explain the phenomenon of the "*bad mother"*, or "*mother-blaming".* Breckenridge and Baldry (1997), for example, adopt a view of structural and personal power relationships to examine the systemic blaming of the powerless (child victims, non-abusing parents) for the actions of the powerful (abuser), stating that "*mother-blame"* is largely misplaced (Breckenridge and Baldry, 1997: 69). However, they found it worryingly common amongst statutory child protection workers who held the most structural power. If this is the case, therapist emphasis on

developing relationships of trust and confidence with parents in order to help them be open is understandable.

Croghan and Miell (1998: 445) suggest that the label of "*bad mother"* threatens self-esteem and identity and resonates with Goffman's idea of "*spoiled identity".* Mothers may resist or succumb to being labelled, although neither route is straightforward, or necessarily mutually exclusive. They go on to say:

> "*... resistance is mediated through socially negotiated representations of reality and is deeply enmeshed in the existing culture. Thus both personal identity and the account maker's perceptions of the identity of the audience for which accounts are presented will be deeply embedded in the social and ideological structures which produce them."* (Croghan and Miell, 1998:446)

Parent interviews included references to "*bad mother stories"* – expressions of mothers' own sense of having let their daughters down, of having trusted someone untrustworthy, of not noticing, of not being there, of failing. Parents in this study were assessed to be "safe carers", but whether and how the label served to mediate or neutralise any personal feelings of failure or responsibility for their children's abuse is unknown. Evelyn's mother said that she felt that people would question how she could let her child be abused ("*I can't believe you did that"*) although she reasoned that they would not actually say so. However, people do think and say such things. Parents in Jensen et al. (2010) expressed similar fears of being condemned by therapists, or of losing control. Constructions of motherhood as a role which appears almost impossible to get exactly right are embedded in the social, political and economic structures, and messages of criticism and reproach, often veiled as advice, suggestions, or rules on how to perform childcare tasks better pervade everyday life. In a discussion of images of "*bad mothers"* in literature over the past 200 years Guardian writer Moira Redmond (2014) wrote:

> *"Mothers can't win – they are mean to their children, they fail to protect them from fathers, stepfathers and random new boyfriends, they are too protective, or not enough"* (Redmond, 2014).

The social construction of the good mother is one who is protective, who represents the *"universal values"* of motherhood as including "*gentleness, empathy, warmth, sensitivity, intuitiveness, and softness"* (Clevenger, 2015:4). For Anya's and Evelyn's mothers, "beating yourself up" may be considered in light of Burr's (2015:218) description of the "*third other",* representing here the concept of the self as constructed in social relationships responding to multiple voices in society criticising them for failing to live up to an ideal vision of mothering. Clevenger described similar comments in her interviews, and found that when women behaved differently to expectations, they reported "*guilt and shame"* which they kept secret:

> "*The types of exchanges the women had with people before as well as after the sexual assault of their child influenced the meaning that they assigned to their behavior as a mother. For the women interviewed, their identity and the way that they 'do mother' appear to be socially constructed through the interactions that they experienced. They reported that they felt compelled to behave or react in a certain way based upon their role as mothers."* (Clevenger, 2015:3)

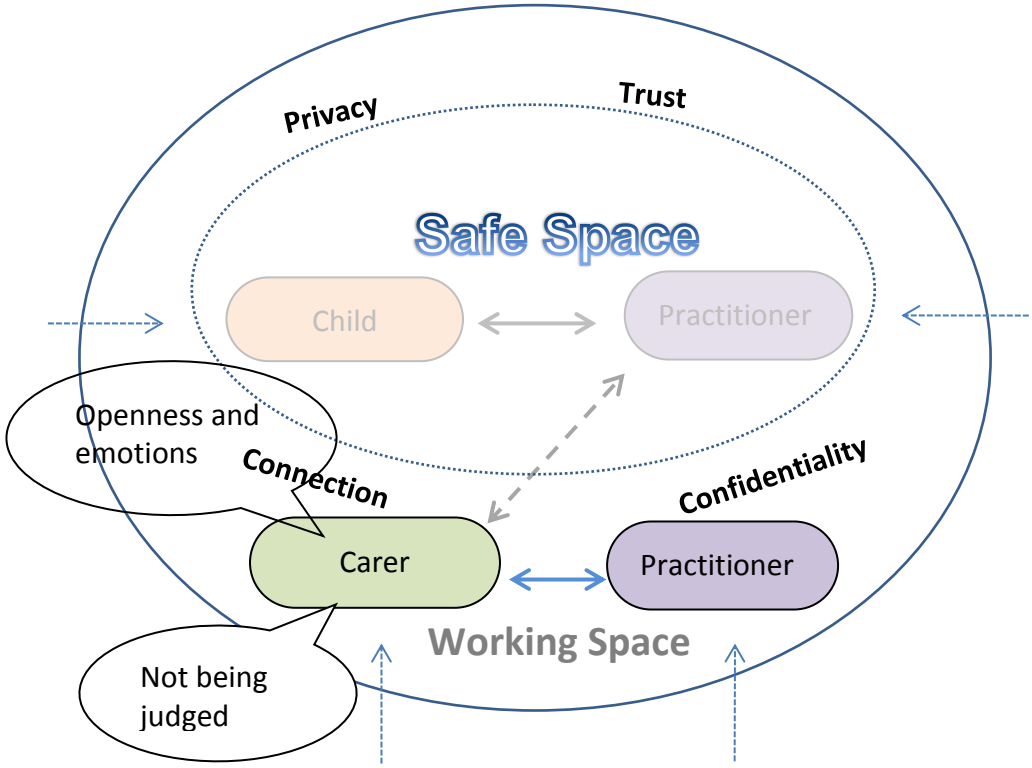
Clevenger argues that "*doing mother"* entails adhering to specific rules and ideals which represent how current society believes mothers should be. Because mothers are, in western society, the primary caretakers for children they are responsible for all aspects of children's health. This responsibility extends to protection from harm (Clevenger, 2015); hence mothers are susceptible to being blamed for child sexual abuse perpetrated by others despite evidencing that they did not know about it (Strega et al., 2008; Caplan, 1998, Krane, 2003) and for failure to protect (Dominelli, 1998; Trotter, 1998). Hill (2001) notes that in most interventions with mothers of sexually abused children the emphasis is on protective capacity and/or culpability rather than on their own well-being and needs.

Men were insufficiently represented in this study to be able to comment on how their perceptions of being fathers might have changed following their daughters' disclosures, and whether or not they felt blamed, guilty, or ashamed. Not having views of other male carers reflects a distinct gap in the research on parents' perceptions of not feeling judged. Fathers are largely missing in much of the literature on support for parents of sexually abused children (Trotter, 1998). There are a number of possible explanations including the lack of accessible and appropriate services available for men, the general observation that males are less likely to reach out for help, and a number of factors related to the gendered nature of child sexual abuse which might make men less likely to participate. Manion et al. (1996) suggest that gender mediates the responses of parents, and that it is mothers who tend to be more profoundly affected. Nevertheless, their research only included extra-familiar abuse cases. Intra-familial and extended family abuse has the potential to severely and permanently damage family relationships and practice experience suggests that, for example, when the abuser is a relative of the father this creates additional stress in the aftermath of disclosure.

7.5.4 Summary

Parental accounts of working with practitioners showed variation. There were similarities with young people's accounts of the importance of feeling that workers were not judging, and that they provided opportunities to talk and listened and showed empathy. For Chelsey's and Evelyn's mothers, gaining trust and feeling safe were emphasised, and like their daughters, they found a connection with their practitioners which helped them discuss issues and emotions. Underlying feelings of letting their children down even though they were not responsible for the abuse were raised in four cases.

Figure 25: Parent themes- working together



7.6 Practitioner Perspectives – working with parents

This section presents the findings on perspectives of practitioners who worked with parents. The themes developed, in line with parental perspectives, include working with openness and emotions and presenting a non-judgmental approach. Although not intended as a therapeutic intervention, the perspectives of practitioners working with parents show, as they did in the previous chapter, similarities to their colleagues' accounts of working with children in relational practice and use of skills and therapeutic approaches informed by trauma.

Figure 26: Parent practitioner themes – working together

Parent practitioners: working together	
Themes	**Subthemes**
Enabling openness	• empathy, understanding • enabling talking and emotion
Respecting choice; working in partnership	• encouragement, not pressure • parents' agenda • using skills and expertise
Not judging	• normalising

7.6.1 Encouraging openness

Parents found it helpful, reassuring and relieving to be able to express themselves to someone who they felt listened and understood, and could be trusted. Practitioners described their approach with parents as welcoming, encouraging and open. These qualities helped ensure that parents felt able to negotiate how they wanted to use the space provided. Evelyn's parent worker was aware from the first session that Evelyn's mother had strong emotions connected with Evelyn's abuse and wanted to give her the opportunity to talk about her own issues without putting pressure on her to do so:

> "*I'd made it clear that it was her space, yes we had some work to do, but it was what she wanted to bring to it, and what she felt comfortable working on."* [Evelyn's parent worker, 160-161]

Georgia's mother's practitioner was aware of her guilt and self-blame, but chose not encourage her to describe the problem because he did not want to risk re-traumatising her. He based this decision on his assessment of her needs, in keeping with a solution-focussed therapeutic approach, and in adherence to the intervention guidance. Whilst encouraging talking, he

discouraged emotional expression which he felt might increase her distress, focussing instead on her strengths as a parent.

The practitioner who worked with Brenda's parents on the other hand, commented on her mother's capacity to monitor and control her own emotional expression in sessions. He expressed some disappointment, almost frustration at not being able to offer more but respected her choice. "*Dancing around the edge*" [Brenda's parent worker, 63] was a phrase Brenda's mother used in a session, a phrase which resonated with their worker. His interpretation was that she was unable to commit herself to be completely open in the sessions as it was not the right place, so they were all *"dancing around the edge"* of powerful emotional issues. The worker commented:

> *"…that's my feeling, that she was ambivalent about it and wanted to be able to use it but didn't trust, also didn't want to make herself that vulnerable, she needed to be strong so she'd let her guard down a bit but then clam up and say 'Oh I've got to be strong.'"* [Brenda's parent worker, 88-91].

Whether or not Brenda's mother would have agreed with his analysis, his perspective on the limits of the relationship is compatible with her view that she did not wish their relationship to be about addressing her emotions.

Chelsey's parent worker summed up her sense of the aftermath of Chelsey's disclosure as an emotional catastrophe for all: it was "*devastating";* "*like throwing a hand grenade into the family";* "*the whole world's turned upside down"* [Chelsey's parent worker, 13-17]. What she hoped to do in her relationship with parents was help them get through the devastation and recover their sense of family and future. The worker reported thinking that Chelsey's father "*was in a very different place where he didn't want … I think he just wanted to keep it in the box really, he didn't want to open it up*" [Chelsey's parent worker, 11-12]. Her thoughts were echoed by Chelsey's mother, who "*engaged really well, she was lovely and she was just carrying so much"* [Chelsey's parent worker, 20-21]. They made a plan and a contract, but the worker allowed Chelsey's mother to "*talk about what she*

needed to talk about … even though I knew my agenda was this, it was about letting her just tell the story" [Chelsey's parent worker, 99-100]. In retrospect, she thought this approach worked:

> *"I think she felt listened to, so I think the trust was there, and I think she felt able to say some things that she'd felt uncomfortable saying, like the anger towards the husband, and then her early stuff as well, which you know, you have to have a level of trust to be able to … there was a warmth about her, and a real – how can I put it, a child-focused-ness from her, she wanted what was best for her kids. And most parents do ... it just felt like she knew what her children needed as well – I think that when this happens ... parents just get knocked off their centre if you like, and they feel like they've failed, they feel ashamed, they feel like, it's almost like the parent compass has gone haywire".* [Chelsey's parent worker, 217-226]

In each of these cases, the parent and the practitioner agreed to work together, and as they created plans and negotiated the space they co-constructed the problems they wanted to address. Practitioners' accounts offer a sense of parents feeling that something in their parenting identity had gone awry, and some despair in not being able to recover what they had as their families had irreversibly changed.

7.6.2 Not judging

The importance of not judging in relationships with parents lies in the construction of relational safety which encourages individuals to participate openly, and in the creation of possibilities for change. Practitioner attitudes which reinforce constructions such as "*bad mother"* stories have the potential to undermine parents' feelings of safety in discussing how they feel, and how best to support their children.

Practitioners aimed to "normalise" parental experiences to reduce their isolation, show acceptance and understanding of parents' feelings, and provide education to help them understand what happened, without criticising. Georgia's parent worker, for example, interpreted Georgia's mother's concern about her parenting to include feelings of guilt so he

worked with her to normalise her emotions, to give her permission to forgive herself for not foreseeing unimaginable events:

> *"I think one of the doubts about herself was 'Have I been a good mum?' cus I seem to remember that her child had spent quite a long time living with the perpetrator…"* [Georgia's parent worker, 171-173]

This is not always an easy task, as Chelsey's parent worker noted. Her technique to ensure that she presented as non-judgmental involved empathising and accepting the parent's reality along with a reflective process of self-checking, monitoring and suspending her own values which might interfere with the working relationship – a process she called "*being aware of my own stuff":*

> *"I think it's being aware of my own stuff, for a start, and it's often that bit about – sometimes I cringe internally thinking 'Oooh, you shouldn't have done that' – not saying it, but sort of giving it back in an acceptable, non-judgemental way. So I think that's quite a skill. And while I could sort of empathise with her, I am not her and I have not had that experience, so being careful not to [say] 'Oh I know how you feel.'"* [Chelsey's parent worker, 387-391]

The non-judgmental attitude helped parents talk about feeling like they had somehow failed. Chelsey's mother's worker reported that merely providing information was not enough. She believed that Chelsey's mother wanted to reflect on it and then talk in a space where they could have a dialogue about how to re-orientate her "*parent compass"*, where she could re-construct a positive image of herself as a parent. The worker saw the quality of their relationship as significant:

> *"...somebody's not going to talk to you about their child who they feel they've failed, and lay themselves open to more criticism if they don't trust the person they're telling...I think that's why people feel afraid to talk about it all the time. 'People will judge me, I already feel like a rubbish parent, if they know this has happened', you know*." [Chelsey's mother's worker, 360-361; 240-242]

The concept of non-judgmental practice is more complex than superficial examination might suggest. Evelyn's parent worker similarly understood Evelyn's mother's sense of guilt and failure. Her emphasis on presenting as

non-judgmental was evidenced in her comment that it was important for Evelyn's mother to feel safe enough to say anything, even if she felt it might be wrong. This worker held a genuine respect for Evelyn's mother's "*instincts"* about parenting. If Georgia's mother's comment that she felt good about being reassured that what she was doing was fine is anything to go by, parents perceived positive judgments as beneficial, and negative judgments as reinforcing constructions of themselves as bad parents.

7.6.3 Discussion

Practitioners in this study reported in similar ways to therapists in Campbell and Simmonds (2011) on the benefits of working in a relational space where parents felt comfortable and trusting enough to discuss their concerns, and where therapists could reassure them that their problems were not unique and their parenting was adequate. The problems brought to therapists express "*our human narratives in such a way that they diminish our sense of agency and personal liberation"* (Anderson and Goolishian, 1992: 28). Anderson and Goolishian view the process of therapy as "*therapeutic conversation… an 'in there together' process'"* (Anderson and Goolishian, 1992: 29). Therapy is described as "*a problem-organizing, problem-dis-solving system"* and meaning and understanding as "*socially constructed by persons in conversation, in language with one another"* (Anderson and Goolishian, 1992:27-28). Practitioners in this study modelled this description, taking the lead from parents and through conversation, using their skills to help parents recover faith, as both Georgia's and Evelyn's parent workers suggested, in their own abilities. That they encouraged parents to be open and expressive evidences practitioner commitment to construct problems and solutions collaboratively, and adopt the kind of "*not knowing"* stance described by Anderson and Goolishian (1992: 28). They understood that there are impacts for parents of sexually abused children, and that these may intersect with any previous negative relational experiences in their own lives. The language therapists and parents used to describe the emotional and cognitive responses to the sexual abuse of their children suggests that

they shared common constructions of sexual abuse as bad, as causing harm to children and their families, as constituting a betrayal of trust and an abuse of power, as entailing consequences ranging from disruptive to catastrophic.

Therapist accounts also indicate intention to work in a non-judgmental framework. It is often suggested in social work that practitioners working anti-oppressively should be value neutral. However, if workers acknowledge that every interaction they have with others is underpinned by values, it is impossible to be value-free. Efran and Clarfield (1992) assert that "*value neutrality"* is impossible to achieve, and that to pretend otherwise is in fact disingenuous and generates a disrespectful and dishonest relationship rather than a non-judgmental approach. Efran and Clarfield suggest instead that workers find commonality of values with service users, such as both wanting the best for children. This approach accepts the existence of multiple realities and choice and ensures that the worker's reality is not privileged over anyone else's. Understanding this way of working provides a model of viewing practitioner approaches to working with parents and carers in ways that enable them to feel they are not being judged or controlled and are able to accept advice and information and interpret these contributions in ways that best suit them. When parents blame themselves, sensing blame or judgment from practitioners would undermine the trust and safety of the relationship.

Practitioners also attempted to "normalise" parental experiences. Normalisation is a complex concept in practice: in one sense, normalising people's experiences is an act which risks colluding with social constructions that oppress, but in another sense it helps reduce people's sense that they are alone in their circumstances. In their discussion of the theoretical framework underpinning narrative approaches, Parton and O'Byrne (2000:51) warn practitioners of the potential to privilege the "*grand narratives that organise people's experiences"* over the local knowledge that people possess of their own experiences. Practitioners' ability to "normalise" in the study context relates to a complex combination of skill and knowledge. The

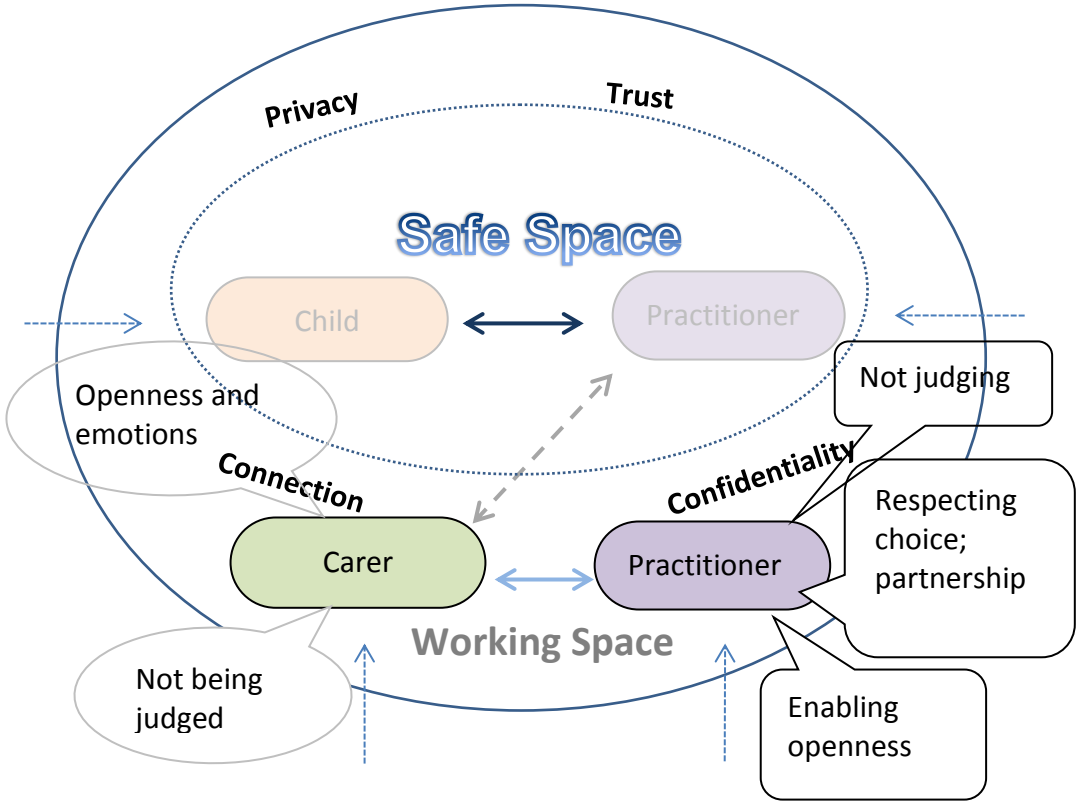
goal of normalising is perhaps to help people feel better about themselves and less alone with their problems, without trapping individuals in narratives which do not represent their reality. Socio-educative work can help "normalise" the experiences of parents of sexually abused children, but for some the additional discussion and meaning-making is particularly helpful. Therapists' understanding of the potential for parents, each of whose situations is unique but who share a common experience, to feel a range of emotions; their ability to engage parents in being open and sharing how they feel; and their relational skills in engaging in dialogues which demonstrate empathy, care and competence without unbalancing the shared power dynamic all contribute to helping parents feel better about their situations.

7.6.4 Summary

Parent practitioners provided accounts which were consistent with the views of the parents with whom they worked. Common themes included the importance of non-judgmental attitudes; providing parents with choice in how they used the space, whether it was to gain information about CSA, resolve their own feelings of trauma, or solve problems; and showing empathy and care. Practitioners were aware of the limitations of the carer intervention in terms of time and focus, and sought to work in partnership taking the lead from parents, but remaining within the boundaries of the guidance.

Figure 27 shows practitioner themes and their relation to the themes developed in parent accounts.

Figure 27: Parent practitioner themes - working in the space



7.7 Chapter summary and conclusion

Although working in the space is presented as a separate topic, it is noted that the relationships between participants described in the previous chapter continued, fluctuated and changed. The interactions which therapists, young people and parents had with others outside the therapeutic space influenced continually what happened within it. The concepts of safety and trust were extended, developing new meaning over time through dialogue and action, resonating with Gergen's (2006) idea of "supplementation":

> "*...as relations continue over time, what is meant stands subject to continuous alteration through an expanding arena of action/supplements.*" (Gergen, 2006:42)

Collaboration, characterised by openness, provision of choice and sharing of power, and a non-judgmental approach can be seen as a pattern in all

working relationships. In respect of young people, the theme of participation was developed as part of the relational process that facilitated their continued engagement in the therapeutic process. This was less prominent in work with parents and it is interesting to consider possible explanations. It may, for participants in this study, be a distinguishing feature of young people's therapeutic relationship but not of parent-worker relationships. Whilst practitioners applied their knowledge and relational skills with parents much as they did with young people, their accounts reflect less focus on therapeutic techniques, and they were not expecting to work with trauma as they did with young people. From parents' perspective, they were motivated to engage in order to support their children, and were not all expecting help for themselves. The relationship with their own workers contributed more to a positive experience of the intervention than to their continued participation. It is reasonable to suggest, however, that without the trust, respect, reassurance and care they experienced in engaging with practitioners they might not have continued.

Findings in this study also support Bronstein's and Flanders' (1998:11) idea of a relationship providing "*the possibility of enabling the development of a space for thinking."* The "work" described by participants here included thinking, reflection, activity, interaction and action pursued within a safe relational space portrayed. The relationships represent "*micro*" social constructionism (Burr, 2015), that is, *"social construction taking place within everyday discourse between people in interaction"* (Burr, 2015: 24). This view does not ignore the wider context, as underpinning all therapeutic conversations is a background story of social and political discourses regarding conceptions of children, childhood, family, sex and abuse, and as discussed in some detail above, mothering.

Young people reported consistent characteristics and behaviour of practitioners towards them, including trustworthiness, warmth, listening, attentiveness, calmness and care. Therapists listening and paying attention were important to young people's feelings of being valued. Also important

was feeling empowered to make choices, voice their thoughts and express their emotions without being judged. These relational qualities helped motivate them to continue to attend despite occasional “blips” and “wobbles”. The views presented in this chapter demonstrate that practitioners accepted young people’s reality and in turn young people felt their workers understood them and were interested. Practitioners set boundaries which young people accepted, but also provided choices and control which young people appreciated. In turn, young people engaged openly and maintained their attendance, even during times when working was difficult.

Parental responses varied in the emphasis they placed on creating a place of safety and trust in which to discuss issues related to their children’s abuse, but all valued a space and professional person with whom to share issues. Parents’ accounts reflected resilience and strength, and focused on what was best for their children. Aspects of the relationship with practitioners which helped them address their issues were acceptance, control of how they used the space, responsiveness and knowledge of the practitioners, and the experience of being able to share their feelings with someone who would not judge. Parents’ various accounts of their own traumatisation, self-blame and guilt, loss of confidence in parenting and sense that their worlds had been turned upside down support findings of Manion et al (1996) and Trotter (1998). Trotter (1998) noted that professional responses are contextual and each case is unique, and warned against generalising about parental reactions to what may appear to be similar circumstances. In a statement that resonated particularly with Brenda’s parents, Trotter also advised that responses which collude with constructions of parents as blameworthy are at best unhelpful and at worst damaging. This study supports additionally a view that professional responses which make assumptions that because parents appear to meet a prescribed level of protective capacity they do not need or want help are missing the opportunity to help prevent the kind of accumulation of negative experiences described by Evelyn’s mother.

Practitioner reports of working within the therapeutic space corresponded with young people's and parents' accounts, and reflected their attention to individual circumstances and differences. Practitioners shared common interests and understanding in building therapeutic relationships, but they each worked in their own individual ways, confirming Bordin's (1979) concept of therapeutic alliance crossing therapeutic boundaries. Shirk and Saiz (1992) indicate both the importance of a developmental perspective on the capacity of children to understand and respond to therapeutic techniques, and the association of the affective relationship (bond) that children developed with collaboration on therapeutic tasks. Part of the collaborative process for practitioners was getting to know each individual child, sharing relational power in the therapeutic process by giving young people choices and enabling them to be in charge, by accepting young people's reality and expertise in their own lives, and by using their knowledge, experience and skills to maintain relational safety and participation. For young people, collaboration involved getting to know practitioners, sharing their thoughts and feelings, exercising their power and choices, and participating in agreed therapeutic activities. Bond and task were distinct concepts, not equivalent but co-related:

> *"…psychotherapy occurs in the context of an interpersonal relationship, and it is the relationship between patient and therapist that organizes the delivery of specific therapeutic techniques…"* (Shirk and Saiz, 1992:714)

It is, as they point out, the "patient" who changes, and therefore without the child's "active involvement" change is unlikely to occur. As one practitioner said, "*I guess we all hope that our clients take away a little bit of us into the world"* [Georgia's parent worker, 350].

Change need not be limited to children and their parents however; hence therapists commented on their own learning, their experience that no child was the same, the building of a repertoire of skills, experience and knowledge over time. Perhaps therapists too take a little bit of each person

they help into their worlds, and that everyone changes in some way. The following two chapters present and discuss participant perspectives of change within the therapeutic space.

8 Chapter 8: Goals and Change in the relational space: young people and practitioners

> *"Change is the conversational creation of a new narrative. We even live through, or co-construct, our lives with the conversations we have with people. This is how we search for new meaning with people that 'dis-solve' problems."* (Parton and O'Byrne, 2000:59)

8.1 Introduction – goals and change

Chapters 8 and 9 offer participant perspectives on agreeing and achieving goals and experiencing change. This chapter examines young people's and practitioners' views on goals and change, considering their accounts through the perspective of change within relationships. It presents findings from each participant group, highlighting the consistencies and patterns in accounts as well as differences, and pointing out the new meaning and stories developed in working together. Talking with participants about relationships experienced in therapy inevitably included conversations about change sought and achieved, although the research interviews avoided asking questions about topics which might risk encroaching on confidential and potentially sensitive territory

Goal-setting is the process of deciding what kind of change is desired. From a social constructionist perspective, the possibility of change grows "*in response to social relationships"* (Payne, 2014:253), framed by solution and future orientated questions: what kind of future would you like and how can we move towards it together? Goals are linked to the possibility of change, which is the purpose of therapy and the ultimate focus of the relationship.

In taking an overview of the therapeutic process, researchers and practitioners may focus on big changes and goals and overlook small changes which occur during the course of therapy. It was apparent in this study that relationships were characterised by small goals and changes as well as defined aims and measurable final outcomes. In the research interviews, participants referred to wishes, hopes, and changes they observed in themselves and others throughout the course of their

relationships, and talked about the new meanings which they took away with them into their everyday lives.

The structure of the previous two chapters is retained here. The first section addresses young people's perspectives on both goals and change, followed by practitioner views.

The chapter addresses research questions 2 and 6:

- Research question 2 asks how bond, collaboration on tasks and agreement on goals is manifested in the relationships described in this study. This chapter presents findings related to how participants understood and agreed goals within their relationships.
- Research question 6 asks about participants' views on change; the chapter presents and discusses young people's and their workers' perspectives.

8.2 Young people's perspectives

The first section explores young people's views on their goals and the changes that occurred during their time with practitioners, and touches on their experience of endings. Section 8.2.1 looks at goals which young people felt they had at the beginning of the intervention, and those which developed as they worked with practitioners, using broad categories of "goals statements" as shown in *Figure 28.* Section 8.2.2 examines the "change statements" (*Figure 29*) in a similar way, highlighting both what young people identified as broad change categories and examples of more specific changes.

8.2.1 Young people's perspectives on goals

> *"It was about the future and how I could change it."* [Anya, 365]

As is common practice, all young people entered into agreements at the beginning of their therapy setting out how they would work during their time together. The intervention guidance proposes that agreements take place at both assessment and intervention phase; agreements in the latter phase

would generally be informed by assessed therapeutic needs. In both cases, agreements would be constructed according to young people's level of understanding. As children's developmental levels, individual circumstances and experiences of trauma varied, it was anticipated that the capacity of young people to define goals would be variable. Literature supports the premise that as young people are less likely to refer themselves for therapy, clear agreement on goals is more difficult to demonstrate than bond and collaboration on tasks (Kazdin and Weisz, 1998; Shirk and Saiz, 1992; Chu et al., 2004).

For ethical reasons young people interviewed for this study were not asked why they were referred, so their agreements with practitioners remained private. However, they were asked if there were things they recalled wanting to achieve or change. As discussed in Chapter 6, young people had some ideas about why they desired help, but their previous life experiences did not include therapeutic relationships. Young people were therefore not expected to be able to define distinct goals before experiencing the relationship within which those goals would be defined or might be achieved.

It is important to note that in this study these were remembered goals, identified retrospectively once change had occurred. Goal statements fall into two main categories, with illustrative examples as shown in *Figure 28*:

Figure 28: Young people - goal statements

Young People's Goal Statements	
1. Different life	a) Be able to enjoy life again b) Move on; have a future c) To be freer; lighter d) Be a different me e) Be safe
2. Help with feelings	a) Anxiety b) Lack of confidence c) Fear, nightmares d) Anger, stress, nerves

8.2.1.1 Different life

Anya, Georgia and Brenda provided different life goal statements. Anya said that she "*didn't enjoy life at that moment"* [Anya, 272] and that although she attended at first because other people wanted her to, essentially she agreed with them, and "*I knew I wanted something different in the future"* [Anya, 273]. It was talking with her worker at their first meeting and listening to the explanation of what the intervention was about that she said made her think:

> *"You don't want to go your whole life with it, then it made me more willing to go, cus I didn't want to keep on living how I was."* [Anya, 276-278]

Because her everyday reality did not feel like a happy space, she wanted to change it but wasn't sure how. Anya's goal in the therapeutic space was to be different in her everyday space. The different life that she wanted involved being able to enjoy herself again, and to regain some control over the direction her life would take. The title of the intervention resonated with Anya who thought that because "*it was about the future"* rather than about reviewing the past she would be able to engage with her worker for help in refocusing on what lay ahead.

There is a sense in Anya's account of feeling stuck, which appears in other young people's stories. Brenda described her aim as to feel "*freer",* as if she were trapped, unable to escape from the way things were, and burdened:

> *"I'm not sure at the very beginning I was quite – not in a very good place, I don't think I thought about aims in the future, but then probably when I got to a better place, my aim was probably just to feel a lot kind of freer, that's probably the right word, to feel a lot lighter and freer ... about things. I'd say that was my aim."* [Brenda, 190-194]

Brenda was unable to see a way out of emotional confusion and distress, and her parents expressed feeling caught up as a family in the investigative, protective and judicial systems which followed the discovery of Brenda's

abuse. Brenda's words appear to indicate a wish to be liberated and unburdened, and, like Anya, to regain control in her everyday life.

Georgia also wanted her life to change, describing her goal as to change herself. She talked of looking back over the previous two or three years and seeing enormous changes, which she ascribed both to the supportive relationship with her worker and her own determination and maturing:

> *"I just wanted to change myself altogether. If you'd of seen me three years ago and spoke to me then and then spoke to me now, you'd just be gob-smacked really, to be honest."* [Georgia, 432-434]

8.2.1.2 Help with feelings

Young people also described wanting help with their feelings. Feelings broadly involved symptoms which are often associated with traumatic experiences, such as anxiety, anger, flashbacks, difficulty sleeping, hopelessness, poor self-identity, and difficulty regulating emotions. Darcie gave a strong account of her struggle with anxiety, her lack of confidence and her tendency to become angry and lash out at people. She did not remember having goals at the beginning of her sessions, and was not sure what she wanted to change. However, she was prepared to have help with troubling feelings that she could not put a name to, but which were affecting her life and relationships. Darcie described feeling then that the world was bad, she was bad, and she could not talk about her feelings, and being encouraged by her foster carer to seek help. It was her carer who put into words during the interview the aim of therapy as she recalled it:

> *"You didn't know what they were, did you. You used to feel quite panicky and frightened when you had strong feelings, and that's why we sort of looked [your **Worker**] up wasn't it, to begin with, cus we said it might be good to talk about it, because you know, that can sort of take some of the power out of it."* [Darcie's carer, 148-151]

Some of the strong feelings which Darcie said she wanted to be able to control and talk about were not feeling safe, always feeling scared, feeling afraid when it was dark, feeling unconfident, and getting angry.

Evelyn similarly did not put into words a memory of why she initially wanted help, but her mother recalled that it was Evelyn who had requested help. Evelyn talked about feeling anxious, nervous, and being unable sleep because she was scared and described her reasons for going as *"to learn techniques, how to control stuff"* [Evelyn, 206-207]. Evelyn noted that her mother supported her all the time, but her "*counsellor*" knew about "*techniques*" like breathing which she could work with every day, so between the two of them she had "*everybody I needed"* [Evelyn, 196].

Heather, having indicated that she did not really know what she wanted to change in her life, showed a page in her workbook on which she had written that her hope for her sessions was to get feelings such as stress and anger back to normal. It appears that at some point she and her worker agreed that these feelings were something they might work on. Georgia, on the other hand, spoke clearly about both her feelings and her behaviour. As noted in previous chapters, Georgia first met her practitioner when she was unsettled, feeling bad about herself and life, and enduring the compounding trauma of a court case. She and her mother agreed to seek help and Georgia recalled that period as generally unhappy, chaotic and particularly gloomy at school:

> *"When I was still at school, I used to be horrible. I really used to be in a bad mood every day of the week, all the time, never used to be in a good mood. [Sigh] School didn't help at all."* [Georgia, 273-275]

Georgia thought that her worker did help however because, as mentioned in Chapter 7, she became an ally, a supportive partner, and someone whom Georgia felt was on her side. This enabled Georgia to feel able to talk about things that bothered her and to choose what she wanted to change, rather than be told what she must change. Her acknowledgement of negotiated rather than imposed goals reflects Gergen's and Kaye's (1992) discussion of

postmodernist therapeutic approaches in which they assert that the therapist's role is to bring resources to share in the relationship, not dictate from a position of knowledge how the client should change:

> *"There is no justification outside the narrow community of like-minded therapists for battering the client's complex and richly detailed life into a single, pre-formulated narrative, a narrative that may be of little relevance or promise for the client's subsequent life conditions."* (Gergen and Kaye 1992:174)

8.2.1.3 Discussion

It cannot be easy to define goals in sensitive circumstances, at the beginning of a foreign process with an unfamiliar person. Young people's goals tended to be broadly defined or related to symptoms, and their understanding of what might change and why they attended varied. Retrospectively, young people talked about goals in terms of the reason they agreed to therapy and in the context of experiencing change, so goal construction over time rather than memory of goals conceived at the beginning of therapy is a possibility, and one which fits with Horvath's (2006) suggestion that:

> *"…as the relationship evolves and becomes more complex, processes like agreement on tasks and goals become increasingly embedded in the therapy routine itself.*" (Horvath, 2006:260)

Jensen et al. (2010) found that children could not articulate goals at the onset of therapy but later could explain something about therapeutic goals. This is more likely to be the case for younger children whose basic understanding of their desire for change and nature of their difficulties does not map to the capacity to do something about them. This presents challenges for goal agreement in a therapeutic relationship (Shirk and Saiz, 1992). In this study, young people identified goals retrospectively. Their initial motivation to attend appeared to be supported by parental motivation, a general wish for their lives to be different and free of particularly troubling symptoms often associated with trauma, and first impressions of their

practitioners rather than by mutual understanding of or capacity to name goals.

This finding contrasts with Diguiseppe et al. (1996) who suggested that tasks and goals were the most important elements of the alliance for young people. Without doubt tasks were important in this study, and are what young people remembered, even if the "tasks" were largely conversation. Separating goals from tasks conceptually, however, this study suggests that goals coalesced as the relationship progressed, similar to findings by Foster and Hagedorn (2014) whose young participants reported that their views on whether or not counselling would be helpful changed over time. The Diguiseppe study pointed out that young people attending therapy may be in pre-contemplative stages of change (Prochaska and DiClemente, 1992), and are referred by other people, but in this small study young people's own accounts indicated motivation to attend and contemplation of initially undefined change at the point of referral. They recognised that they wanted something to be different, but did not know what. Given that in most cases parents/carers were the referrers, that young people were generally as Brenda put it "*not in a good place",* and that they did not know what to expect and were anxious about the prospect of "therapy" it is hardly surprising that defining goals at the outset was challenging.

Brenda's example is perhaps more closely allied to the pattern identified in the Diguiseppe study: although Brenda noted that it took a while to trust her worker, her practitioner perceived that Brenda found engaging initially difficult because other people, not her, had defined "the problems". This may not have been Brenda's perception of her referral; perhaps she wanted help but it did not look like the help that others saw as important. Agreed goals for Brenda evolved within the relationship, demonstrating the importance of creating the safe space described earlier. Brenda and her worker, in O'Hanlon's words, were able to "*collaboratively construct"* both the problems and the solutions through their "*therapeutic conversation"* (O'Hanlon, 1992:136).

It was evident that goal development was for some young people mediated through hope, which was a characteristic of the therapeutic relationships. Brenda's and Anya's statements about wanting to be freer, lighter, and to have a different future are indicative of the experience for individuals who have experienced trauma of despair as unending. Hope is vital for young people who feel trapped and desperate to see even the possibility of change, let alone conceive of achievable goals. As Briere and Scott (2006:69) note: *"Hope is intrinsic to effective trauma treatment."* The previous chapter noted that in their relationships with young people, practitioners were positive, focused on strengths, and reinforced early progress. Young people responded to positivity and experiences of progress, as discussed previously, and as can be seen in the next section on changes they perceived in their lives.

8.2.2 Young people's perspectives on change

Young people had unique views on change. Discussions about change developed in the context of questions about how young people thought their time with practitioners helped them, either generally or in relation to specific problems they spoke of in interviews. Change statements are represented by two broad categories, shown in *Figure 29*, with illustrative examples.

Figure 29: Young people – change statements

Young People – Change Statements	
1. Life changes	a) Having a changed life b) Being in a better place c) Having a future d) Seeing the world differently
2. Everyday changes	a) Using learned techniques b) Improved relationships

8.2.2.1 Changed life/better life

Anya, Brenda, and Georgia said their whole lives had changed for the better, with Anya and Brenda attributing the changes to their practitioners. Anya, when asked how she thought knowing her worker affected her, responded

> *"I'll always, I'll always remember it, cus it was such an important time in my life, so I'll always remember it, and I think cus she changed it so much."* [Anya, 325-326]

She added that one of the impacts on her thinking was understanding that "*there is a future, like not just seeing it as now"* [Anya, 372]. This understanding came, she said, from her worker getting to know her and talking with her about what she wanted for herself in the future. The fact that her practitioner could relate their discussions specifically to Anya's thoughts about what she wanted to do when she was older made her "*feel more reassured about it all"* [Anya, 376]. The process represented the relational context of working towards change, the construction through dialogue in the therapeutic space of future possibilities for Anya to consider and action in her everyday spaces, after the therapy had finished.

Brenda also credited her worker with changing her life, with the shift she experienced from "*not a good place*" to a *"better place"*:

> *"I do believe that she changed my life, and I don't believe that I would be where I am now if she hadn't of met me."* [Brenda, 220-221]

Like Anya, Brenda talked about how this change occurred within a relationship of trust and safety, and about the importance of feeling *"openly able to talk",* and to feel reassured that moving to a different kind of place was possible. It was good, she said,

> *"...to have someone to kind of tell me that it was going to get better and to reassure me so then I kind of did get to that place..." [Brenda, 206-207] and "when I got to a better place it was more just that I wanted to feel that way."* [Brenda, 196-197]

It appears from Brenda's account that like Anya she discovered possibilities of being different within the therapeutic relationship, and then wanted to continue feeling better as she completed and moved beyond her sessions. For both girls, feeling hopeful was important.

Georgia also acknowledged her own agency in turning her life around, and the significant part her practitioner played in helping her. She could not explain how, but in the context of a discussion about whether there were any particular times with her worker which stood out, said:

> *"There was one [time] where I was like really struggling with everything, like I couldn't cope with school, I'd fallen out with my mum cus she kept like, I don't know, like I kept like walking out, and she'd ring the police on me, and I'd get a report missing every night, and I was drinking a lot, I was taking drugs a lot, and I don't know, she just helped me through everything really. If it weren't for her, I wouldn't be where I am, really."* [Georgia, 68-73]

Georgia noted, as others did, the importance of encouragement and hope. She realised that in the months that she spent seeing her practitioner, she also matured. She said she had not taken drugs for a year, and was engaged in a training course which she loved. She spoke with a sense of maturity and perspective about her relationship with her mother and with her previous peer group, with whom she no longer had much in common. In talking about how change occurred, Georgia noted "*it's myself that's helped myself change but it's just nice to have somebody there to encourage you"* [Georgia, 209 -210].

8.2.2.2 Everyday change

Young people also talked about small changes which affected their lives and relationships in everyday spaces. Heather enjoyed talking about other relationships with her practitioner: her friends and peer group were important in her life. As Heather did not know what she could or wanted to talk to her worker about when they first met, the routines of structure and content evolved over time. Whilst not defining precise goals, she was able to talk

often through the medium of her workbook with her practitioner about what interested her and what events and problems she experienced in her daily life, and mostly these involved her friends. In discussing what had changed in her life through working with her practitioner, Heather responded:

> *"I'm still the same person. But I think my moods have changed, so I've got on better with keeping my moods in, and not lashing out all the time into fights."* [Heather, 317-318]

Heather's workbook represented a kind of record of dialogues she had with her practitioner, which helped her develop different strategies in everyday interactions with her friends. These were changes she saw herself making, a view she offered in response to a direct question about whether she thought she had changed after her sessions.

Darcie also described changes in her life which she was able to effect herself once she knew how, but she did not believe her whole life had changed*: "It didn't really change my whole life, it just changed my attitude and the way I look at the world."* (Darcie, 135 - 143). She and her foster carer had a conversation in the interview about how Darcie had become better able to control fear and anxiety, gained confidence, and "*valued"* herself more. Darcie described the process of change using as an example meeting her worker for the first time. Looking back, she considered how scared she was about doing something new, meeting a new person; how she became more relaxed and comfortable as she got to know her worker; how her worker helped by explaining things in a way that Darcie could understand; how they tried things out (eg breathing, relaxation techniques) in sessions before Darcie tried them outside. The developing bond affected her confidence, which encouraged her to try things (take actions) related to her goals, which in turn affected her everyday relationships. She described her own thinking process, an internal dialogue in the context of conversations with her worker, particularly in relation to realising her capacity to have control in her life:

> *"...she'd* ***[Worker]*** *just say 'You're a lovely girl, no matter what happens, just you know, realise that you know, you're gonna be*

> *fine.'... All them positive words that you can think of. And after she was saying that I was like, 'Yeh, I will do that.' And I didn't do it straight away … but I listened to her, and like 'I will do that' and then I could see myself, like one day I did it, and like 'O my gosh, what was I angry about?' you know I was thinking, 'Did I really need to be angry? Did I need to be upset?' you know it's just like life… I surprised myself I think!"* [Darcie, 101-108]

The first direct speech passage underlined above indicates Darcie's perspective of the positive messages that the practitioner gave her. The remaining passages illustrate Darcie's perceived gradual incorporation into her life a different way of relating with the world.

Evelyn talked about change prosaically: she learned techniques that she could use to control her symptoms. She and her therapist worked together on ways to feel less nervous, less scared at night, and less angry with other people. Evelyn compared learning ways to help herself deal with fear and anxiety to taking medicine – she reflected that people could take tablets to feel less anxious, and she found the techniques worked for her. She described a conversation she recalled having with her worker which created possibilities for feeling less nervous:

> *"We were talking about what made us nervous, and I said when a teacher asked you a question and you had no idea what it was. And she said 'What would be a way to show that you weren't nervous?' and I said 'Just breathing slowly' and she said 'Well how can we slow that down?' and I said 'I don't know' and we started that and it really helped."* [Evelyn, 54-58]

Evelyn's advice to other children who were going to have the same intervention was to go, because "*she's really good at like making yourself better*" [Evelyn, 331-332].

8.2.2.3 Discussion

Young peoples' accounts of progress are contextualised within the therapeutic relationship. They represent local knowledge, that is knowledge produced within a particular relationship, and demonstrate what Bruner (1986; cited in Parton and O'Byrne, 2000:47) describes as "*landscapes of*

action" and *"landscapes of consciousness",* as young people reported both actions and interpretations of what happened. Similarities are apparent in concerns which for some young people coalesced into goals, notably about symptoms, and in changes where they reported symptoms as resolved, partially or fully. Similarities are also seen in young people's views on the importance of hope and future, which helped them accept first that change was possible, and then that they could make it happen themselves. Parton and O'Byrne (2000) identify the significance of this understanding, especially for young people who through victimisation had experienced the undermining of their sense of worth and of agency:

> *"Establishing an 'internal locus of control' is essential for the empowerment especially of those who are victims in various ways ... It also opens the door to multiple possibilities of change for the future and for more control of many aspects of one's life. Indeed, it is key to the building of all solutions, to full participation in goal development, for example."* (Parton and O'Byrne, 2000:60)

There is, as Gergen (1998) points out, a tension within the social constructionist movement over the place of individualism and agency which is relevant to the discussion of young people regaining control and agency in their lives. Therapy works with individuals, individual expression of emotions and thoughts, and personal struggles and solutions. Constructionism, as Gergen notes, is often *"chastised for its deconstruction of humanist assumptions of subjectivity and human agency"* (Gergen, 1998:42). It also perhaps exemplifies the difference between what might be described as constructionist versus constructivist thinking and raises issues familiar to practitioners, particularly in Western cultures, committed to social change and working with individuals for whom sense of agency and autonomy are important. For some practitioners, there may always be an underlying dilemma in helping individuals and families to 'fit in' with social structures and conventions which are viewed as oppressive or discriminatory. This dilemma relates, in turn, to a long-standing discourse about the role of social workers, particularly in statutory services as either agents of social control or promoters of social change (Parton and O'Byrne, 2000:69) or as Payne

portrays it, as caught in the discourses between empowerment, social change, and problem-solving social work views (Payne, 2014:21).

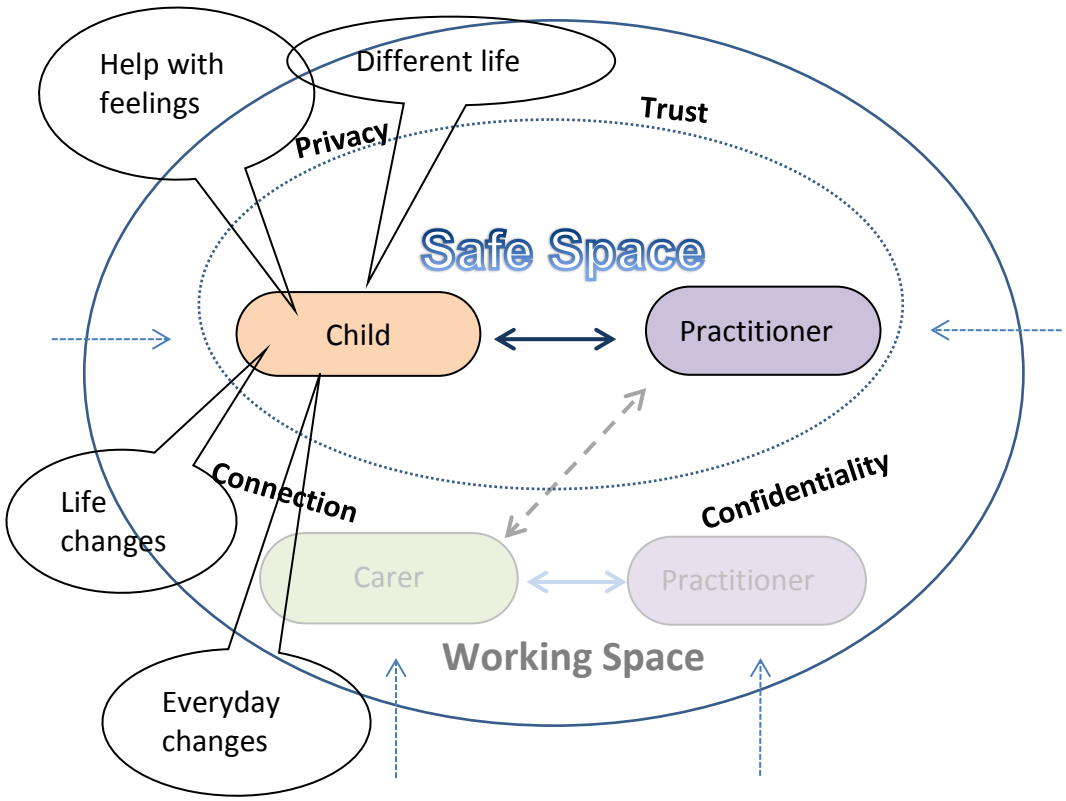
Young people's views on the impact that their therapeutic relationships had on their everyday lives are significant. Brenda's, Georgia's and Anya's perceptions of life-changing effects were views shared by participants in the Foster and Hagedorn (2014) study. In terms of importance of spaces in their lives, the everyday space is the important one and the purpose of therapeutic space for young people is to help young people move beyond it, taking with them what is important, and feeling improvement in their lives. This is part of what Parton and O'Byrne (2000:60) talk about in reference to the *"amplification"* of personal agency, particularly with people who have been victimised and feel powerless. Reassurance, hope, and encouragement were features of young people's change reports.

Darcie's and Evelyn's reconstructions of their conversations with therapists can be viewed as representing the "*constructive conversations*" (Parton and O'Byrne, 2000:59), or "*progressive narratives*" (Gergen and Gergen, 1986, as cited in Parton and O'Byrne, 2000:58), implying a joint movement toward goals, negotiation of meaning (exploring what Evelyn meant by feeling "*nervous*" for example) and recognition of change. Recognising change is important – it leads to a sense of achievement and empowerment, and emphasises the capacity of individuals to have some control in their lives. In this intervention, it was also important in labelling progress as real, to maintain hope and self-belief not only for young people, but also for parents, for whom their children's change represented a principle goal.

8.2.2.4 Summary

Figure 30 shows themes developed in young people's accounts of goal setting and change:

Figure 30: Young people's perceptions of goals and change



This section has examined goal and change statements in young people's stories. The types of goals statements made by young people were derived from discussions in interview about what they wanted to change or achieve in working with their practitioners. They described goals which developed gradually, in conversations with their practitioners, relating to both specific

difficulties and general dissatisfaction with their lives. Feeling stuck, burdened, and unable to see the future, and wanting life to be different represented undefined goals which young people and their workers developed together into a focus for their sessions. Small changes helped young people to feel hopeful and empowered. The challenge for young people to state goals at the outset in an unfamiliar process, particularly in times of crises, have been pointed out with reference to relevant research.

Young people's views on changes were positive, reflecting feelings that their everyday lives were different, and that their relationships in the therapeutic space helped them change. Their accounts are retrospective, goals are remembered in the context of change that has already occurred, so these accounts cannot provide a chronology of events leading to change, and that is not their purpose. They provide insight into how young people viewed the process of change in the context of working with practitioners, and emphasise the importance of the relationship in creating a space of safety in which to talk about change. The following section presents practitioner perspectives on goals and change in young people.

8.3 Practitioner perspectives – goals and change in young people

"*Cus it's about helping people grow."* [Anya's worker, 60]

This section presents findings on practitioner perspectives on agreeing goals and achieving change with young people. Practitioner accounts reflect goals informed by the assessments and plans recorded with each child and parent, and filtered through the professional lens of knowledge and understanding about trauma, sexual abuse, attachment, and development across the lifecourse. The sharing of power described in Chapter 7 enables young people and parents to negotiate goals with their workers, although practitioners work under an umbrella of agency goals which set boundaries on the actions they take in practice.

8.3.1 Practitioner perspectives on goals with young people

Young people's practitioners talked about goals consistent with the agency aim to help children and young people recover from the impacts of child sexual abuse: healing, focusing on the future, and repairing relationships. The concept of healing from trauma, which underpins the intervention, was represented in all practitioner accounts in various ways. Also represented was a goal of helping young people position their abuse in the past rather than experiencing it as impacting pervasively on the present. This focus on the future reflects the ethos and aims of the intervention to keep children safe now and in the future. Finally, there was hope expressed that the relationships established and the work done within them would help young people with their current and future relationships outside the therapeutic space. The goal statements are shown *Figure 31* below.

Figure 31: Practitioner goal statements - young people

Practitioner Goal Statements – Young people	
1. Healing	a) Reduce/explain symptoms, impacts b) Feel better – work on feelings
2. Future focus	a) Be different in the future/move forward b) New narrative about what happened c) "Achieve something better"
3. Repair relationships	a) Attachment perspective b) Keeping safe

8.3.1.1 Healing statements

> *"So part of the stuff is to try and make links if you can so they can see why these things are important, where they may have come from, why do they feel the way they do, why do they behave the way they do, like why are they ... what was that about, you know about friendships and things like that, and then it's like well actually, 'Let's have a look at that'."* [Anya's worker, 92-96]

Healing for CSA survivors is a holistic concept, encompassing recovery from crisis, integration of traumatic experiences, restoration of problem-solving and emotional regulation and "*reconnection with daily life"* (Goelitz and Stewart-Kahn, 2013:3). Practitioners' goals for healing included all of these aspects, and recognised that specific goals would vary with individual children. Young people's practitioners made reference to goals of alleviating and/or explaining symptoms and helping them feel better.

These goals are consistent with young people's wishes to have help with their feelings. Heather's worker found that Heather gradually indicated things that she wanted to change in her future. These included wanting to feel better about herself: "...*actually, she just felt, I think, quite rubbish about herself"* [Heather's worker, 156]. Her practitioner adopted Heather's goals and they were incorporated into the issues they addressed in her workbook. Anya's practitioner, in providing explanations about her emotional

experiences, wanted her to "*understand these processes"* [Anya's worker, 399-400] because she believed that such knowledge gives young people power. She described how she imagined Anya's concern and distress about unexplained symptoms adding to the sense that there was something "wrong" with her:

> *"I think sometimes for many young people, it's about helping them understand – 'What's just happened, why is it affecting me the way it has, why do I feel like this, why do I have flashbacks, why can't I sleep at night, why does my heart race and stomach churn every time I do this, that and the other', and helping them to understand sometimes these processes give them a bit of power. A lot of it is about helping them to reclaim their own power so they don't feel as afraid. And also about helping them to trust the emotions that they have in their body, so 'If you're starting to feel inside that you're upset and you're anxious, why is that? What's happening around you? What is going on that's triggering you?'"* [Anya's worker, 396-404]

The first "direct speech" (underlined) section in the passage above represents the worker's interpretation of how young people think about their symptoms in their own words rather than the language of the therapist. The second underlined section references the concept of contextualising emotions, or thinking about feelings.

Chelsey's worker described Chelsey as a "*worrier",* a little girl with "*pseudo-maturity*", who was becoming "*highly aroused"* and "*emotional*" [Chelsey's worker, 98] at home and who came to her sessions with what seemed to be a surprisingly clear idea for her age of what she wanted to address in her sessions. Her practitioner phrased her goal as to work on what Chelsey brought to the relationship, to help her be a child who no longer had nightmares and anxieties, "*to help her be a little girl, and not to be worrying about her parents and all the ramifications to her disclosing"* [Chelsey's worker, 44-45]. Although Chelsey did not provide her perspective, her mother's account corresponds with the worker's report of Chelsey as a child who knew what she wanted and seemed to engage with her worker immediately.

Frances's practitioner did not talk about goals. As the previous two chapters noted, Frances's engagement seemed ambivalent and, as her worker noted at times, "*awkward"*. The worker reflected that perhaps as Frances did not refer herself, she was merely going along with attending and either did not want to talk about problems, or alternatively did not feel she had a problem worth talking about. In other words, someone else was defining or constructing the problem (O'Hanlon, 1992). If there is no problem, there is no therapeutic solution for, as Gergen notes, therapy also is a cultural construction (Gergen, 2015). If parents believe young people have "a problem" yet young people have a different view, therapeutic collaboration is difficult if not impossible, an observation which practice wisdom confirms. Because Frances also declined a research interview, there is only the practitioner's perspective on their relationship, so the question of goal agreement remains unanswered:

> "*...the actions that we might normally describe as 'therapeutic treatment' do not become so until clients are willing to collaborate with the view."* (Gergen, 2015:170)

Brenda was another young person who got on well with her practitioner but with whom initially agreement on goals was tentative. Her worker described this as a 'mismatch' of purpose:

> *"Yeh, it didn't match. So I think it was that real mismatch, and I still had that original thought about 'how am I going to work with this? How am I going to be able to help', with someone who originally didn't really want to change or was fine with how things were so that was that 'Oh, now I've got people here saying I really want things to be different,' she was 'no, this is how, I've chosen this'."* [Brenda's worker, 451-455]

The "direct speech" sections marked represent the worker's portrayal of voices in an unspoken dialogue about barriers to agreeing goals, and illustrate her reflection on how to respond to what she perceived as Brenda's view of her situation. The practitioner also described how she understood Brenda's change of mind. For the worker, the turning point was represented

by her decision just to be on Brenda's side, to avoid being drawn into the investigation, to go back to where Brenda was. Her goals were clear:

> *"'I'm here for Brenda, I'm not part of that, you know, I want her to heal, and she needs to do it at her pace, and this is not what we're about here... it's about healing from a trauma.'"* [Brenda's worker, 129-132, recalling a conversation with parents about her role]

When Brenda was safe, her worker saw that she wanted specific things like other young people – to be rid of flashbacks and nightmares, and not to cause worry for her family because she felt bad about that. She spoke about how she saw Brenda's goals developing:

> *"And I think they changed, because initially, because she was still in that situation I don't think she saw – what do I think? – I think she was playing along with it. It wasn't about what she wanted, it was OK for her, you know, 'It's a relationship, I'm just doing what other people want me to do' and then when it came out she was safe, it was about – not wanting to self-harm was a biggy, because she was so embarrassed about that, and she felt really upset about the impact on her family."* [Brenda's worker, 323-328]

Brenda's worker described small goals agreed with Brenda within the overall healing goal. Small goals emerged in the ongoing dialogue about changes, indicating that goal collaboration is a continual process, not a one-off unchangeable agreement. Goals developed around agreed areas. Some small goals were represented by Brenda's worker finding out about a symptom and wondering if providing information and explanation (a task) would help Brenda feel better; some goals were about agreeing on particular issues which arose in the course of the *EMDR* treatment, so that each session would start with a discussion about what to work on that day.

8.3.1.2 Future focus

Goals by definition relate to the future. The future focused goal statements referred to here were those that emphasised specific aspects of a young person's future life which therapy might affect. Anya's worker, for example,

spoke of the impact that sexual abuse has on children's sexual development, trust, and emotions in future sexual relationships and her hope that through the intervention she might help Anya avoid problems in the future:

> *"...part of my job is to test out, are these things getting in the way of her having a future sexual relationship with someone? …so you're constantly having to check things … if there's a situation with a boy, a boyfriend, 'How is that? How is she finding that? Is she comfortable with that? Is she scared of that?' You know, you've got so many different things, and if you're trying to work holistically … it's all part of dealing with the impact of the abuse, it's looking at the way it affects the next part of your life."* [Anya's worker, 418-419; 425-430]

As Anya also was focused on "*how she could change"* her future, she and her worker were in basic agreement about goals. Evelyn's worker, recalling her discussions with Evelyn about what she wanted from her sessions, agreed that they could work on issues of her choice, and hopefully "*achieve something better"* for her future:

> *"...she was talking then about how she felt it could help to come to [Agency] and she was really keen, and sort of clear about what she worried about, and what she thought about in her head, and how she wanted me to help with that. So from the very beginning it was quite clear. We can, we can do some work here, and hopefully we can achieve 'something better for you'."* [Evelyn's worker, 283-287]

Evelyn was able to "*pinpoint"* things that she wanted to work on as part of her agreement when she first started sessions, and her worker described her as "*driving"* the path of the intervention. Change in the future for this group of young people meant addressing issues of the present involving events from the past. In Evelyn's case, the worker felt that although the abuse occurred many years before, it had deeply affected her mother as well as Evelyn, so that between them, they kept issues alive through the years, and that the time had come to put them in the past.

8.3.1.3 Repair relationships

The possible impacts of CSA on relationships include mistrust, confusion, and loss of connections with friends and family either as a direct result of the abuse or as an indirect consequence of emotional, mental health, or behavioural difficulties (Howe, 2005). Therapy provides the opportunity to establish an experience of a safe, consensual, and reparative relationship in order to restore young people's capacity to experience positive relationships. Recalling the discussion in Chapter 4 (section 4.4.6) about establishing an ethical relationship to counter the experience of an abusive or unethical relationship, the therapeutic relationships were clear in their intention to cause no harm. In this study, relationship problems with parents or peers were presented as issues by practitioners, parents/carers, or young people themselves. Where young people described tensions in their relationships with others, practitioners adopted helping young people to resolve these as part of their goals.

Darcie's worker heard both Darcie and her carer highlight relationships as potential area for change. Her worker saw Darcie's goal to "*sort of try and get over"* an "*awful experience"* she had when she was younger, which had been triggered recently. The impacts affected how Darcie felt and acted with her friends and with her carer. The practitioner believed that by providing a relationship where Darcie felt valued and listened to, her sense of value and self-worth in her other relationships might be restored. Hence the worker offered:

> *"…a reparative relationship I think, in some ways, because a lot of the relationships she'd had before hadn't been and so she was able to sort of like use the relationship just like a secure base really, to do more things herself, you know a bit like a parent-type relationship."* [Darcie's worker, 17-20]

The relationship aimed to provide a platform for relational change. As attachment theory proposes children use the secure base to explore the world safely, so in therapy Darcie could use the relationship to explore her

social world and try things out in relationships with others, including her carer.

Heather's worker also perceived one of their goals to be working on relationships because Heather often brought to sessions discussions about peers, friends, and boyfriends and questions about how to decide which relationships were 'good'. Goals of healing and relationship repair are interlinked as workers anticipated that progress in one area would facilitate progress in the other. Heather's worker noted that her awareness of Heather's feelings of low self-esteem and poor confidence grew as their relationship developed and Heather revealed more about how she felt about herself and others. The context of the quote below was a question about what the worker perceived as things Heather wanted to change in her life. Her description of how the focus of the work changed over time supports the idea that young people and workers agreed goals gradually and at young people's pace, rather than at the beginning of the intervention:

> *"I think a lot of it was about her views of herself which didn't come out 'til later on, but she had very low self-esteem, things like body image, and all the stuff around relationships which is more what she's talking about, was feeding into that kind of negative view of herself and the stuff about problems with her dad was feeding into it, and some of that was related to the historical abuse and how her family dealt with that at the time and it was just kind of a knock on effect – actually she just felt, I think, quite rubbish about herself, and ... towards the end that was what we sort of started to focus on."* [Heather's worker, 150-157]

8.3.1.4 Discussion

Parton and O'Byrne (2000) point out that solution focused practice is "*pragmatic",* that as practitioners we ask what people want, how they define it, and how they will know when they achieve it. This is goal definition from a practice perspective. de Shazer portrays it as "*language game"* which therapists and service users play together "*thereby creating the social and interactional conditions for producing progressive narratives focused on*

change and goal achievement" (de Shazer, 1991:124, cited in Parton and O'Byrne, 2000:66). As long as the game is played fairly, with genuine efforts to use language which is mutually accessible, goal setting can be viewed as collaborative.

In agreeing goals with young people, practitioners maintained commitment with agency goals whilst attending to young people's statements of problems they wanted to work on. Where they were unsure about young people's goals they demonstrated patient and reflective approaches, as illustrated by Brenda's and Frances's workers. The direct speech examples provided by Heather's and Anya's therapists highlight the difference in the language they used with young people and the language of the research interviews which were characterised by words and phrases of the professional world and therapeutic traditions. For example, theory of trauma impacts and processing and their representations in the body became, for Anya, simple questions about why she might feel the way she does – "*Why does my heart race? Why can't I sleep?"* and low self-esteem was in the worker's perception of Heather's reality as feeling "*rubbish"* about herself. In Darcie's case, the worker's attachment perspective can be seen in the language of her interview whereas Darcie's and her carer's language on exploration from a secure base was simpler, as Darcie talked about trying things out in her social world after considering them in the safety of her sessions, and her carer talked of gaining confidence in her relationships. How practitioners perceived the change achieved through their collaborative efforts is reported in the next section.

8.3.2 Practitioner perspectives on change in young people

> *"...all we're really doing is having conversations."* [Anya's worker, 635-636]

This section presents practitioner perspectives on change they observed in young people with particular attention paid to accounts indicating change

through relationship. Practitioners talked about change in young people as intermittent and gradual, as occurring dramatically in some sessions, and as elusive or uncertain. They noted periods where they just seemed to be meeting to talk or play, and also moments where they felt they had observed a breakthrough or a young person had reported a major change. Changes were sometimes elusive, particularly where, as in Heather's and Frances's case, there was little formal contact with parents who might have confirmed differences. Categories of change statements are shown in *Figure 32*.

Figure 32: Practitioner change statements – young people

Practitioner Change Statements – Young people	
1. Pace of change	a) Gradual or intermittent (treading water) b) Sudden or dramatic
2. Nature of change	a) Disappearing symptoms b) New narrative re abuse c) Change in relationships d) Emotional change
3. Elusive change	a) Hoping and hypothesising change

8.3.2.1 Pace of change

Practitioners' accounts indicated change that was gradual but not continuous. Chelsey's worker commented that by the end of sessions her behaviour at home and her relationship with her mother changed over the 18 months or so that they worked together. Chelsey became less of a worrier as she was encouraged to talk through her worries. Change was gradual, however, and there were points where:

> *"... it felt a bit like treading water you know, and I was thinking 'Oh, what else needs to happen really?' but maybe that's what needs to happen sometimes, just to consolidate, you know… why would you be expecting change to be happening every week?...I mean, in spurts of growth, aren't they, and then maybe you just need a little rest."* [Chelsey's worker, 423-428]

Anya's therapist, in discussing the impacts of shame on sexual abuse survivors, talked about how particular issues may take some time to "*tease out"*, time in which change is not apparent:

> *"...it's such a multi-layered thing, you just have to try to tease the things out a little bit and it takes time, and that's why the relationship is so important, because if that young person doesn't feel able to show the most vulnerable parts of themselves then they're not really going to do the work with you. And my job is to try to find ways to enable them to do that. So … you need a certain amount of time to be able to find out what works for them because each child is going to be different."* [Anya's worker, 140-146]

Her words suggest the importance within the therapeutic relationship of safety, patience and commitment to moving at each young person's pace. She knew when she had found what worked for Anya and other young people because there would come "*a session which really shifts something"* [Anya's worker, 147]. When this happened, she said that she would point out change, and suggest to young people "'*if you have benefitted from that, maybe do something like that again'"*. Anya's worker noticed that Anya tended to be, in her words, "*less likely perhaps to challenge*" [Anya's worker, 30-31] and reflected on how to help her change. Her description of the kind of conversation she had indicates her use of dialogue within the relationship to create opportunities for change:

> *"I say 'You're saying you're fine, but are you really fine then? I'm not sure that I would be if I was you.' So I put those things in I think sometimes, depending on who it is I might even do like a slight role shift, and story, you know, changing the characters in the story, and then when they see it through somebody else's eyes some are more likely to accept it than through their own."* [Anya's worker, 161-166]

Georgia's worker saw gradual change in Georgia's presentation and outlook, and felt, like Anya's worker, that it was helpful to discuss changes as they occurred:

> *"I think it was useful for her to have someone to talk to about it each step of the way, and then to actually see her from A to B, and to be able to reflect, 'Georgia – that's fab that you haven't smoked in 2*

> *months!' or whatever … or 'Oh Georgia, do you remember when you used to talk to me about feeling so angry that you could do this, and now look at you – you're sitting her and saying that you're doing th –' just reflecting those changes, because I think that she couldn't see it in herself always, and sometimes, being able to talk with her about actually, 'That is remarkable how you've done that, and keep going'."* [Georgia's worker, 403-410]

Brenda's worker alluded throughout her interview to the importance of proceeding at the young person's pace and noting positive change. During the period spent preparing for and beginning trauma processing she did not expect to see change, but she hinted at concern that perhaps the technique would not be successful:

> *"We spent quite a few months doing stabilisation work, which is about resourcing and finding a safe place, making sure that there was lots of safety there before we actually went to the memories, which was really difficult, and we seemed to sort of go over them again and again. And I admit at one point I thought 'Will we ever get there?'"* [Brenda's worker, 153-157]

However, she then described the kind of shift that Anya's worker mentioned – a dramatic and obvious change, a "*breakthrough",* in one session where Brenda:

> *"...visualised running from danger into safety, and it was just there in her face... she said that afterwards, she said 'I just feel, you know, it's gone'.... And afterwards, she just said 'Ah, I can't believe...' [this is whispered]".* [Brenda's worker, 365-367; 159]

Change, when it occurs suddenly and after much effort and time, can seem wonderful and breath-taking, recalling again Gergen's comment that "*effective therapy often seems magical"* (Gergen, 2006:28).

8.3.2.2 Nature of change

Practitioners reported on overall and non-specific changes in young people, as well as specific changes. The alleviation of symptoms was a goal in all cases, so it is unsurprising that when asked directly how they thought young

people had changed during their time together practitioners reported their observations on symptoms.

Darcie's worker commented that Darcie had achieved "*massively more than it was ever initially thought that we were going to do"* [Darcie's worker: 231-232], and that their relationship was key: *"I think it built her confidence really, being able to be the leader in the relationship in a lot of ways*" [Darcie's worker, 65-66]. This account corresponds with Darcie's and her carer's views on the process of learning in her sessions and then trying things out in her everyday spaces. Georgia's worker too saw many changes reflected in her ability to talk about them herself:

> *"I think from a girl who was quite quiet, and maybe a bit reluctant to engage, maybe had some bad experiences in the past, to somebody who was able to smile, laugh, talk about how much things had changed for her, how she was doing things differently, how she was focusing on the future, I just think it's incredibly powerful."* [Georgia's worker, 434-438]

Practitioners noted reduction in symptoms such as nightmares, anxiety, and anger. Discussions with young people and their parents informally or in reviews were important sources of information, validating changes that workers thought were occurring, and also useful in consolidating progress by making it real. When Evelyn began to talk more about her friends and activities than about flashbacks, anxieties and nightmares, her worker interpreted this as a sign that symptoms were reducing, an observation which Evelyn confirmed:

> *She said things like 'My nightmares have almost gone really', whereas at the beginning she described nightmares a lot of the time, the sort of flashbacks... those thoughts and fears really reduced as the work went on, so her anxieties – her tummy pains, and headaches – seemed to really reduce. What I noticed more in sessions she started to talk about her friendships a lot…* [305-311] *…she talked about a real reduction in the anxiety symptoms, and being able to use some of the things that we'd done together to sort of help her relax and help her feel more confident when she started to feel anxious."* [Evelyn's worker,305-311; 328-331]

Workers also noticed changes in young people's self-perceptions. When Darcie told her practitioner "'*I've actually decided that I don't want another boyfriend at the moment, I just want to be me'"* [Darcie's worker, 202-203] she connected Darcie's decision with a change in how she felt about herself. Chapter 6 mentioned Darcie valuing the relationship because she could "*be myself*". Wanting '*to be me'* indicated to the worker increase in self-esteem, confidence and self-belief in a young person who had previously said that even her carer didn't like her and just "*put up with*" her. People with low self-confidence and belief find it difficult to understand how other people can like them. Those who have been abandoned deliberately or through loss or bereavement, emotionally neglected, or rejected may feel this way (Howe, 2005). Darcie's 'new' identity matched the changes that the worker was seeing and the carer's reports on how Darcie's relationships with others were changing.

Finally, workers spoke of change in young people's understanding and management of their emotions. Practitioners saw understanding as achieved through conversations normalising emotional responses to trauma, as Brenda's practitioner did, and management of emotions through activities related to expressing anger and relaxing, as Anya's and Darcie's workers did. Evelyn's worker recalled Evelyn's words on feeling less fearful that she could be abused again, and less frightened to be away from her mother:

> *"Towards the end of the work she talked really clearly about what had happened, but also, quite amazing really in terms of the sense that she made of it, which was it was a one-off, it never happened again, and 'Now I know it can't happen again'."* [Evelyn's worker, 241-244].
>
> *"And that bit about needing her mum close by did reduce quite significantly, and she developed this little thing of being able to say 'I know my mum's close by and she always keeps me safe, nothing can happen to me we are family'. And that was her little mantra if she felt anxious as well. So she talked about using that and being able just to have more confidence in situations without her mum."* [Evelyn's worker, 331-335]

Change was also monitored by the endings of therapeutic relationships. Sometimes practitioners were satisfied when young people wanted to end; other times they were not. Anya's, Brenda's, Chelsey's, Evelyn's and Georgia's workers ultimately supported the decision to end sessions. Anya's worker said that they stopped after about 20 sessions because they agreed she didn't need to come anymore. One of Anya's goals was to be able to enjoy her life, as she was unhappy when she started therapy:

> *"And that's what I was saying, it was - she did the work and she was fine. So I was sort of thinking, 'Well, OK ... I don't really think there's much more we can do really, you seem to be happy', she says, 'I am really.' You know, and it's about, my work is always to keep checking, to keep going back to the event to see how much of it is left that triggers her. By the time we'd finished, she didn't seem to be having any triggers at all. So, for me, that was a very successful piece of work. And she seemed to be out there, behaving like a typical teenager..."* [Anya's worker, 616-624]

Other workers made similar statements. Brenda's worker noted that she and Brenda agreed on how to end, and that she knew the time was right because *"she just seemed ready to go out and live"* [Brenda's worker, 434-435]. Evelyn's worker made a comprehensive statement about her understanding that they had accomplished what Evelyn wanted and that it was time to finish. She had developed a different narrative about her abuse which made sense to her: *"I could see 'This is how she has come to think about what's happened', that's so different from the beginning"* [Evelyn's worker, 298-299]. She was at first taken by surprise when Evelyn said she did not feel she needed to come anymore, but accepted the reason she gave, which was that she wanted to get on with her life with friends, she was practising the things she learned at home and they had helped. These sentiments corresponded with Evelyn's mother's goals to let her be a 10 year old:

> *"...she didn't feel that she needed to come any more, she had done what she needed to do, she had thought about things as much as she wanted to, things that we'd done had helped and she was using them at home, but she didn't want to think about her abuser anymore and*

what he had done and she wanted to get on with her friends and her life with her friends." [Evelyn's worker, 35-39]

8.3.2.3 Elusive change

The practitioner who worked with Frances and Heather expressed uncertainty about change. The girls' circumstances were different, but a common factor in both cases was that parents were not receiving *Agency* support and were less directly involved. For Heather, the worker could only say that she thought that they "*made progress*", but that she did not accomplish everything she might have. She recognised, as did Heather, that there were areas of Heather's life that she chose not to bring to the therapeutic space. In Frances's case, although the worker perceived a change in their relationship, she did not know how or if this change manifested itself in Frances's everyday life. Frances ultimately chose to talk with her practitioner about relationships, and the worker could only assume that this was where problems which Frances wanted to resolve lay. However, she was not confident in saying that they had co-constructed "the problem" (O'Hanlon, 1992) let alone goals or solutions. When Frances decided she no longer wanted to come, her worker was unsure whether this was because she had succeeded in resolving problems – in O'Hanlon's words, what she "*was complaining about is no longer perceived as a problem"* (O'Hanlon, 1992:139) – or it was simply no longer convenient. Frances' worker was left with what became a positive relationship but without clear therapeutic purpose or obvious change.

8.3.2.4 Discussion

If it is accepted, as Parton and O'Byrne (2000) do, that it is the service user's, not the therapist's/social worker's view of change that matters, it is possible to argue that whether or not the worker found it difficult to identify changes is not relevant to Frances's and Heather's experiences of the therapeutic relationship because changes may have happened in their

everyday spaces, they may have found solutions to problems, and these may or may not have been connected with their therapy. For practitioners, however, outcomes feel important. In part this is because the purpose of therapy is change and agency outcomes are judged by change that occurs, but in addition, observing positive change following investment of time, emotions, expertise and care in a relationship is rewarding.

Focusing on change in terms of relieving symptoms plays into social constructions of trauma impacts as indicators of mental health problems, a focus which Gergen (2006) places firmly in the arena of deficit discourses. It is not necessary to view symptom-relief in this way however. At some point before or during their therapy most young people in the study wanted to feel better, have better relationships, or put the past behind them, and their parents and practitioners wanted the same things. As Gergen points out, although research is "*equivocal"* on the question of how effective the multitude of therapeutic interventions are, "*it is clear that many who seek help believe their condition is improved as a result"* (Gergen, 2006:107).

Practitioner and young people's accounts were consistent in reporting change relating to impact on their everyday lives, especially in terms of improved relationships and symptoms. There are examples in all participant accounts of dialogue introducing possibilities to construct new meaning in situations and in identity, to reframe narratives related to abuse so that they became less toxic or intrusive, and to redefine social relationships so that they were more collaborative and characterised, as Gergen (2006) might say, "*co-ordinated action",* not only in therapy, but in everyday life. These examples suggest that from participants' perspectives the therapeutic relationship played a part in the change process, that trust and safety were necessary in order to open the dialogues, and that the dialogues promoted thinking about change and about the future.

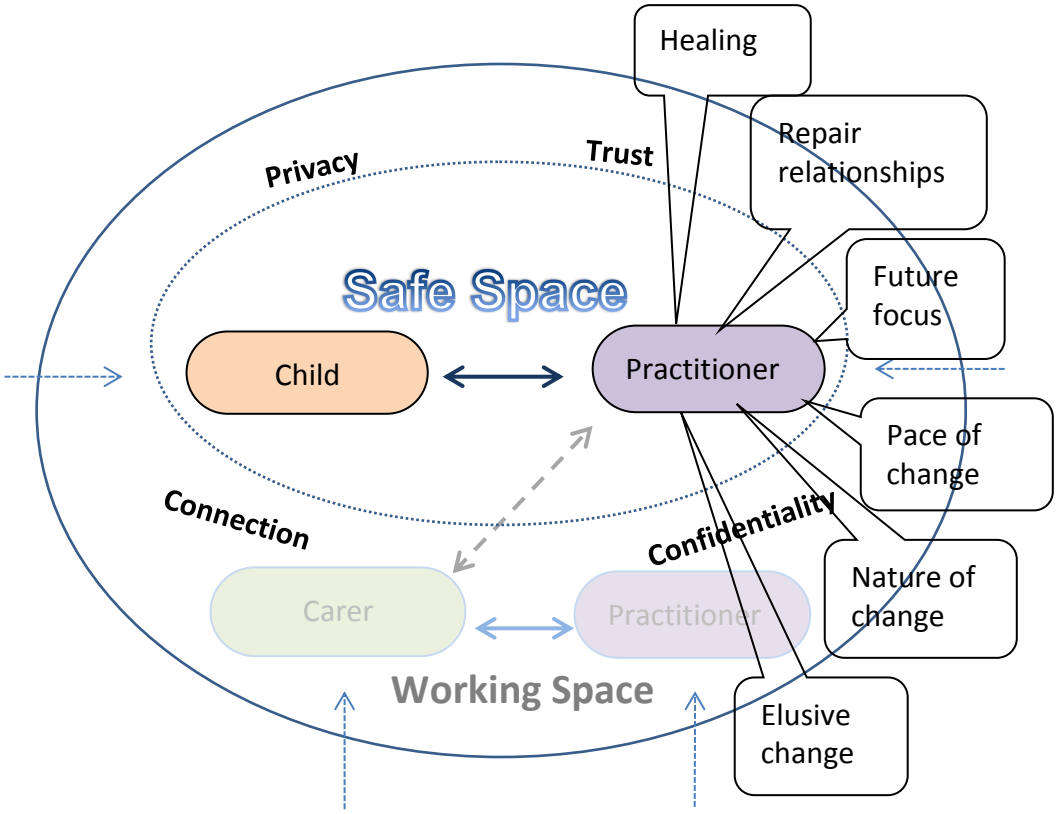
Frances's case presents an interesting exception to the dominant picture of positive change. The practitioner's account of working with Frances includes development of trust and safety, but not expressed with the certainty seen in

other accounts. Importantly Frances's voice is missing, so she cannot confirm or challenge this view. This does not mean that the practitioner's view is not accurate – only that it represents reality from her perspective, whereas in the other seven cases there were at least two voices heard on the subject of change in relationship.

8.3.2.5 Summary

Themes from practitioners' accounts on goals and change in young people can be seen in *Figure 33:*

Figure 33: Practitioner themes on goals and change with young people



This section has provided practitioners' views on goals and change for young people. Goals were seen to develop within the context of the relationships, along with co-construction of the problems which young

people wanted to resolve. Practitioners had theories and hypotheses derived from particular therapeutic approaches and provided examples of how they used their knowledge and skills to provide explanations for problems and open conversations about possible solutions. Whatever their therapeutic experience and orientation, practitioners aimed to be led by young people so that they did not define problems which young people did not share. In terms of goals, broadly, any issues related to trauma experiences which were causing a problem for young people could be included. Practitioners wanted young people to be living their lives – to be free from CSA impacts which potentially stigmatised, traumatised, and isolated them. Associated with healing were the goals of helping young people focus on the future and repair relationships damaged by their abuse experiences and the relational ripples which often follow sexual abuse. The gradual pace of change matched the gradual development of goals. Given that the object of change was to affect young people's lives outside the therapeutic space and practitioners were not part of young people's everyday lives, it is not surprising that change appeared sometimes elusive, and workers relied on hope and hypotheses in describing what they perceived to be positive changes. Where parents or parent workers were able to validate progress, young people's workers could be more certain that their perceptions were accurate.

8.4 Chapter conclusion and summary

This chapter has explored young people's and practitioners' views on the development of goals and observation of changes in young people. Young people's clarity about their initial goals for change was variable. They made goal statements representing themes of wanting their lives to change and to have help with feelings. Some young people acknowledged that they just wanted life to be different and others described not wanting to experience symptoms anymore. Some wanted to move on, have better relationships with others, or just have a future. Practitioners described compatible goals

related to healing from trauma, repairing relationships, focusing on the future and leaving the past behind. Practitioner language in the interview was professional, demonstrating their knowledge as experienced practitioners, but also incorporating everyday language of young people in describing how young people presented to them and in direct speech examples of how they spoke with young people.

Young people and practitioners described change, sometimes dramatic, other times gradual; sometimes clear and other times difficult to pinpoint, but all eventually positive. Examples of how young people talked with their therapists about change, from reducing symptoms to relating better with others provide insight into the capacity of a safe and trusting relationship to open new possibilities through dialogue. “Dialogue” was not always verbal – it involved activities, movement, drama and art, and sometimes silence. Endings were ultimately prompted by young people, despite some expressing anxiety about whether they would continue to feel better. Sometimes practitioners knew the ending was coming because they could tell from conversations with young people that they no longer felt a need to talk about problems; other times they were surprised. Where both young person and practitioner were interviewed, it appeared that their accounts corresponded on both development of goals, and nature of positive change.

The following chapter continues the theme of goals and change, presenting and discussing findings on parent and practitioner perspectives.

9 Chapter 9: Goals and Change in the relational space – parents and practitioners

> *"Change in therapy is the dialogical creation of a new narrative, and therefore the opening of opportunity for new agency …We live in and through the narrative identities that we develop in conversation with one another."* (Anderson and Goolishian, 1992:28)

9.1 Introduction – goals and change from parent and practitioner perspectives

This chapter presents parents' and practitioners' perspectives on agreeing goals and experiencing change. The presentation of parent perspectives includes analysis of the relevant questionnaire responses and comments on change from the wider sample of parent responses to the *Carer Feedback Questionnaire (CFQ)*.

The definitions of goal-setting and purpose of the intervention are as presented in the introduction to the previous chapter. However, the service context is different. Consideration of parent and practitioner goal and change accounts in this context requires acknowledgement that the scope and focus of the service was more limited and the relational framework less clearly defined than for children.

This chapter addresses research questions 2 and 6:

- Research question 2 asks how bond, collaboration on tasks and agreement on goals is manifested in the relationships described in this study. This chapter presents particularly the evidence on how participants understood and agreed goals within their relationships.
- Research question 6 asks about participants' views on change, and the chapter presents and discusses parent and practitioner perspectives.

9.2 Parents' perspectives: *CFQ* Analysis

This section begins with a brief description and analysis of questionnaire responses and comments by parents who completed the *CFQ* in the evaluation. The analysis of questionnaire data provides a backdrop and

context for the discussion of more detailed accounts by participants in this study.

9.2.1 Description of *CFQ* and sample

The *CFQ* was designed to gather feedback from carers at the end of the service about what was helpful. It comprises three questions and a comment box. Questions 1, 3(a) and the comments provide data relevant to this chapter. Question 1 asked participants to rate, on a 5 point scale from *strongly agree (1)* to *strongly disagree (5)* eight statements about how the work they did helped them by ticking the appropriate box.

The statements, reproduced in *Table 5* with response frequencies in each category, broadly represent the remit of the carer intervention, and can be interpreted as embodying its goals, or the areas where it was hoped to achieve change. It was anticipated that these areas would constitute parental areas of concern, but not all parents would perceive need for help in every area. Carer ratings of what helped may be interpreted as representing areas of perceived change, so are useful in setting the scene for the qualitative findings from parents' accounts of goal-agreement and experienced changes.

Question 3 asked parents to rate, along the same scale, the relationship they had with their worker. Statement 3(a), *"My worker and I agreed on the goals of the work",* is of most relevance here. Finally, question 4 was an open comment box, and invited participants to comment in any way about the help they received.

The sample comprises 85 carers and parents whose children received a service, who were offered a service themselves, and who agreed to complete the questionnaire. Completed questionnaires were collected as part of the evaluation.

9.2.2 Analysis of CFQ questions 3(a) and 1

An overwhelming proportion of carers responded that they and their workers agreed on goals of their work. Eighty-two (n=85) participants responded to question 3(a) by agreeing or strongly agreeing with the statement *"My worker and I agreed on the goals of the work",* and there were no negative responses. The majority, 47 individuals (55.3 percent) strongly agreed, 30 (36.5 percent) agreed, and 4 (4.7 percent) neither agreed nor disagreed. Cumulatively, 95.1 percent agreed or strongly agreed with the statement. The results are shown in *Table 4*:

Table 4: Carer responses to CFQ question 3(a) on goal agreement

		Frequency (N=82)	Valid Percent	Cumulative Percent
Ratings	Strongly agree	47	57.3	57.3
	Agree	31	37.8	95.1
	Neither	4	4.9	
Total		82	100.0	100.0

Table 5 shows the results of a frequency analysis of responses to CFQ Question 1. Responses are interpreted as relating to change. Figures in brackets are the valid percentages based on the number of people who rated each item. Not all carers answered all questions, perhaps because they only rated the areas relevant to their needs. However, at least 78/85 (91 percent) carers scored all items. The figures show that generally carers rated the help they received positively. For seven out of eight items at least 74 percent of those who responded agreed or strongly agreed that they had been helped in each area. Only the item on dealing with carer feelings about the perpetrator of the abuse scored cumulatively lower than 74 percent for the 'agree' and 'strongly agree' scores, but even that was positively rated overall with 69.2 percent of scores positive. This item also received the highest percentage of neither agree nor disagree ratings (21.8 percent), and of negative ratings (9 percent).

The items have been rearranged to rank them in the order from highest to lowest percentage of carers agreeing, showing totals of strongly agree and agree columns.

Table 5: Frequencies - number (percent) carer ratings of items in CFQ question 1

Help Received	N	Strongly Agree	Agree	Neither	Disagree	Strongly disagree	Total agree
F. Helped me understand my child's needs better	83	43 (51.8)	32 (38.6)	7 (8.4)	1 (1.2)	--	75 (90.4)
H. Helped to support my child's use of the sessions	83	39 (47)	35 (42)	9 (10.8)	--	--	74 (89.2)
B. Dealt with my negative feelings about child's abuse	79	37 (46.8)	32 (40.5)	6 (7.6)	3 (3.8)	1 (1.3)	69 (87.3)
G. Increased knowledge about how to protect my child from further abuse	79	34 (43)	31 (39.2)	13 (16.5)	1 (1.3)	--	65 (82.3)
C. Helped me cope with feelings of isolation following child's abuse	79	34 (43)	31 (39.2)	12 (15.2)	2 (2.5)	--	65 (82.2)
A. Increased knowledge and understanding about child sexual abuse	81	30 (37)	35 (43.2)	13 (16)	3 (3.7)	--	65 (80.2)
E. Helped me to re-establish good relationship with child	82	39 (47.6)	22 (26.8)	16 (19.5)	4 (4.9)	1 (1.2)	61 (74.4)
D. Dealt with my feelings about the perpetrator of the abuse	78	31 (39.7)	23 (29.5)	17 (21.8)	5 (6.4)	2 (2.6)	54 (69.2)

9.2.3 Discussion of CFQ findings, Questions 1 and 3(a)

As the areas where help was offered were informed by research and clinical experience with parents of sexually abused children, it is not surprising that question 3(a) was rated positively. Although these were not therapeutic

relationships, the concept of goal-agreement in any helping relationship is important in working towards change. The intervention offered possibilities to carers of developing different strategies to support children who had been abused. It focused on solutions rather than problems, advising carers that the Agency recognised common issues which parents may experience, and suggesting that practitioners had the skills to help construct different ways of understanding parents' and children's responses, and of protecting and supporting children.

These were goals which parents experiencing the levels of stress found by the evaluation were likely to find appealing. Parents completed the Parenting Stress Index (Short Version) (*PSI-SF*) (Abidin, 1995) at the beginning of the intervention (T1) and then at six months intervals (T2) and (T3). It found that about half of the carers had initial total scores showing clinical levels of stress which had not reduced by T2. However, it also noted that in most cases the carer intervention was provided towards the end of the child's service (Carpenter et al., 2016) and that by T3 the proportions of carers with clinical levels of stress had significantly reduced in the control and waiting list groups.

Carer responses to Question 1 indicate positive experience of being helped, which possibly contributed to alleviation of stress. The area with the highest cumulative percentage of agreement was on item (f) (*helped understand child's needs)*: almost all carers scored the item, and 90 percent agreed that their worker helped them understand their child's needs better. The second highest scoring item was (h) (*helped support child's use of sessions)* with 89 percent of carers feeling that sessions helped them better support their child. These two items are linked by an underlying assumption that greater understanding helps create the possibility of change in parenting, at least from the carers' perceptions, although the pathway may be different for each individual.

The item showing the lowest proportion of carer agreement on being helped is item (d), dealing with feelings about the abuse perpetrator. This item also

had the fewest number of responses. Feelings about perpetrators are likely to be varied and complicated, and depend on the relationship of the perpetrator to the carer and the child, the carer's own experiences of abuse or violence, abuse characteristics (duration, extent, child's age, how long ago the abuse occurred), level of knowledge/understanding of CSA, and the nature and existence of support networks. Thus scoring on this item is ambiguous. Negative scores may be given by carers who felt they have already dealt with their feelings or for whom the question seemed irrelevant, or by carers who have strong feelings which cannot be resolved within the scope of the carer intervention.

The scores are useful for feedback to the agency about areas which were most helpful. However, without access to accounts of how help and change are perceived, there is a limit to the usefulness of the questionnaire in understanding the process of change, particularly within the parent-worker relationship. Carer comments in response to question four provide some context and are discussed briefly below.

9.2.4 Carer comments, CFQ question 4

The comments reveal carer views on satisfaction with the service and contain limited references to experiences of change. Sixty-three out of 85 carers provided comments. The majority (57) were positive, wholly or in part, about relationships with practitioners, change in child, or change in carer. Three of these comments contained both positive and negative comments: one reported that carers' sessions were not useful but that the child healing was "*the greatest help*", and the other two expressed a view that whilst the sessions were helpful there were not enough child sessions, and in one case carer sessions. Six comments were ambiguous or critical, but related to availability of services generally, or issues specific to the process or individual cases. Thirteen comments were generally positive but unspecific. Mostly these expressed gratitude for the service or to the workers, or acknowledged that the service was generally helpful. Nine comments related

to the positive relationships with practitioners, describing them as supportive, friendly, kind and compassionate.

Thirty-four comments are interpreted as relating to positive change in the child, the carer, or both. Changes for children included general feedback about “progress”, “recovery” or “healing” as well as specific areas of change such as dealing with or expressing emotions, feeling ready to “move on”, or gaining confidence and self-esteem. Comments related to carer change included references to gaining information and learning, dealing with emotional impacts, and feeling less at fault for what happened. Several comments specified how carers felt the practitioners helped them. The benefits for carers of information and knowledge from workers included, for example, being able to “*understand the issues*” or “*understand the situation”* affecting the child. One carer cited the difficulty of previously feeling isolated with no one to talk to about the “*challenges and emotions we faced both as a family and individuals*”. Carers also cited being helped to cope with their own emotions, with one describing that the support “*made me feel it was OK to find the work and the situation difficult”* and another describing the support as helpful to “*come to terms with what happened”.* Three carers expressed reassurance that what happened was not their fault.

Overall, the comments suggest positive views on the intervention and its helpfulness for carers and children. The questionnaires and comments provide a snapshot, useful for the service in evaluating feedback from carers on how it helped, but limited in analysis of carers’ perspectives of change within relationships with workers. The following sections examine carers’ accounts of goal agreement and change in qualitative interviews and provide greater insight into carers’ views of how these processes occurred in the context of relationship with practitioners.

9.3 Parental perspectives on goals

Parents in the study were not always able to say exactly what they wanted or expected until they began to meet with their workers. All parents involved with the intervention entered into an agreement at the beginning and

received information on the stated aims of the carer intervention. However these were novel and distressing circumstances for parents so it was for some difficult to define precise goals for themselves.

Parents did not necessarily expect change themselves although they had goals related to their children. Even those parents who had some experience of helping relationships (mothers of Darcie, Georgia, Brenda), although able perhaps to be more specific about goals for young people, were less clear about their own goals. However, parents developed goals for themselves as they began to engage with their practitioners and form relationships in which they explored possibilities for change. Parental perspectives on goals for themselves and their daughters have been categorised into "goal statements" which are presented in *Figure 34* below.

Figure 34: Parents - goal statements

Parental Goal Statements	
Goals for self	**Goals for child**
1. Parenting goals a. Be helped to support child in therapy b. Be helped to cope with child's behaviour c. Reconnect as a couple d. Be free to "be mum" 2. Personal goals a. Feel better/have help with own emotions	1. Recovery goals a. Feel better/recover from trauma b. Deal with overwhelming feelings c. End symptoms of distress – eg nightmares, anxiety

9.3.1 Parental goals for themselves

9.3.1.1 Parenting goals

Parents made statements indicating that they wanted help supporting their daughters in therapy, and coping with behaviours and symptoms associated

with sexual abuse experiences. The statements are consistent with areas represented in Question 1 of the *CFQ.* Anya's father explained that their initial expectations were based on the practitioners' offer that "*'We're here to help you with how you can support Anya at home'…it was a pretty simple mission statement really"* [Anya's father, 212-214]. The offer acknowledged that parents might have difficulties coping with child behaviours related to abuse; suggested that young people might find the therapeutic process stressful and that this response might spill over to home life; and created the idea of partnership between parents and practitioners to help the child. Anya's father noted that their goals were in agreement with those of the agency:

> *"I think the initial goals was how we could help support the work that [**Anya's worker**] was doing with Anya, I think that was the first thing."* [Anya's father, 106-107]

Georgia's mother's initial goal was also to get help coping with Georgia's behaviour and supporting her through her treatment. Although as a professional she understood many of the issues relating to child sexual abuse, she sought information and reassurance about her parenting strategies and helping Georgia. As a single parent, she had no one at home to support her or tell her whether she was doing the "*right thing*". She liaised with both her own and Georgia's worker regarding everyday concerns for Georgia's well-being and safety. She sought advice from both workers, but her goal with her own worker was to gain more information and reassurance. At times, she said,

> *"I used to doubt myself, and I'd think, 'God, this just is going on for far too long, and I'm really getting concerned now, am I doing the right thing, I must be doing something else, is there anything I can change'?"* [Georgia's mother, 289-291]

Chelsey's parents also struggled with Chelsey's behaviour, so shared the goal of seeking advice and reassurance about their parenting. Chelsey's mother said that Chelsey's behaviour changed so much that she *"didn't know how to cope with it, well, we both didn't know what to do"* [Chelsey's

mother, 101-102]. She took all the information, leaflets and fact sheets offered home to read them because *"I very wanted to learn about what would make things better"* [Chelsey's mother, 104-105].

9.3.1.2 Personal goals

Parents did not necessarily expect to have emotional support for themselves. Anya's, Evelyn's, and Chelsey's parents each reported that the relationship with their workers met their needs in ways they had not anticipated. They thus negotiated secondary goals once the relationships with workers were established and they felt more confident to open up about how they were feeling. Anya's father described this as their "second" goal:

> *"And then the second was the sort of if we ourselves needed help, or to talk to somebody, get things off our chest, sounding board, I guess."* [Anya's father, 107-109]

Anya's father's phrase "g*etting things off our chest"* suggested a view of the relationship as an opportunity to air feelings, to talk about issues that troubled them. Anya's mother sought additional and qualitatively different help in her individual session. She felt that she was "*stuck",* that even as Anya was improving, she was still "*beating herself up"*, struggling to "*let go":*

> *"I was … just sort of going round and round and being angrier and not really after sort of a year not felt any differently or moved on."* [Anya's mother, 29-31]

Evelyn's mother described guilt as a big issue yet she did not have specific goals when she met her practitioner because she had not expected to be offered support. Her goal was to talk to someone who could help her support her daughter to recover. However, the relationship with her worker enabled her to be open and honest about her experience of ongoing impacts, and they worked together on the emotional problems she brought to sessions. Thus her goals developed within the relationship. Evelyn's mother and her practitioner identified that her feelings of guilt and self-blame were preventing her from moving forward and were represented by an internal dialogue of responsibility:

> *"It was just like the logic in my head was saying 'Of course this wasn't your fault you know, this was a person you could trust, everyone did', everyone trusted him, but in your heart it's like 'I wasn't there for my daughter and she needed me'. So it's just like a conflict."* [Evelyn's mother, 102-105]

The 'direct speech' passages marked illustrate Evelyn's mother's conflict and perhaps express the feelings of other parents in similar circumstances. The internal dialogue, the *"third other"* (Burr, 2015:218), influenced social interactions in everyday spaces and provided a kind of self-monitoring and assessment of relationships. Her first goal was to learn to deal with the guilt that she felt by resolving the longstanding conflict between what she described as messages from her head and her heart. She spent time talking with her worker about "*what was going on in here, really, and trying to get it out"* [Evelyn's parent, 232]. The second goal was to improve her relationship with her daughter by having support to become a different kind of parent who felt more comfortable letting her child have more freedom. She described herself as "*over-protective*" and thought that this caused her daughter to worry about her. These were interconnected goals, linked to intense, chronic and "*debilitating"* stress which she said affected both their lives.

Chelsey's mother experienced similar feelings. She reported that she thought she "*wasn't normal"*, and that she might be the only person who struggled with her daughter's and with her own feelings. She did not know what she wanted from her worker when they started meeting but later recognised that reassurance that what she was feeling was 'normal' was important to her. This represented the beginning of a new conversation where she was not the only person who felt as she did, and she and her worker were then able to agree that resolving her own traumatic responses would be part of her sessions.

In all cases parents perceived agreement with their workers on session goals. Georgia's, Evelyn's, and Chelsey's mothers expressed doubts about their roles and identities as parents. Brenda's parents chose a different focus

for their sessions, negotiated with their worker as described in Chapter 6. Their goal became to discuss what had happened and how they were dealing with it as a couple in a facilitative space with practitioner as witness. They did not plan in advance, as Brenda's mother noted:

> *"I had no expectations, so it wasn't something I thought about until I got there. Simply because I couldn't, my mind was too full of other things... It just evolved.… I didn't have space to think about it before we were in there, but that's how it worked out. And afterwards we reflected on it and said actually that is what we need, and so outside of the session we realised afterwards that we were both wanting that."* [Brenda's mother, 58-59; 218-223]

Brenda's parents had been distressed by events which affected every aspect of family life. From Brenda's mother's view, one of the most important and poignant aims in engaging with the intervention as a whole was to obtain help for her daughter that would, in her words, *"free me up to just be mum… someone else could be the therapist, and I could be mum"* [Brenda's mother, 136-137].

Parental goals for themselves were related to goals for children in the sense that they represented a way for parents to contribute to the healing process by gaining understanding of CSA and their children's responses, and by ensuring that they were emotionally able to deal with their own responses.

9.3.2 Parental goals for their children

9.3.2.1 Recovery goals

Parental goals for children emphasised recovery. All parents wanted their children to be helped to recover from the emotional impacts of trauma. Brenda's mother expressed the view that as all her children had been affected by what had happened, she made sure they would each get help, *"… because this is my children's future"* [Brenda's mother, 200].

Anya's parents were similarly determined:

> *"For us it was just like we would do anything to get Anya down this road to feeling better, you know, or seeming to feel better, and it was ups and downs and everything but that's all we wanted."* [Anya's mother, 233-235]

Emotional recovery goals were inextricably connected to behaviour change goals. Parents hoped for family life to be "normal" again, for young people's symptoms to lessen, and for outward signs of emotional distress and confusion to abate. Georgia's mother's statements of concern about her daughter revealed her goals to be related to her daughter achieving safety and emotional stability. Darcie's carer recognised that Darcie's feelings had been overwhelming her and causing anxiety and hoped that Darcie's practitioner could help her understand them and gain control over them rather than finding they controlled her. The implication is that this was a carer goal from the beginning, one agreed with Darcie.

Other parents identified particular symptoms as recovery goals. Chelsey's mother understood that Chelsey had been diagnosed with PTSD, and that her behaviour and emotional changes were associated with her diagnosis. Her behaviour had "*totally changed"* [Chelsey's mother, 101], she experienced nightmares and became uncharacteristically anxious and angry, symptoms which were distressing for Chelsey as well as her parents. Evelyn's mother recalled similar symptoms interfering with Evelyn's life and her relationships in her everyday spaces.

9.3.2.2 Discussion

Research and clinical experience over the years have demonstrated that parents are negatively affected by their children's experience of sexual abuse whether it occurs within or outside the family network (Trotter, 1998; Manion et al., 1996). Parents in this study focused on getting help for their children, and any help they sought for themselves was primarily in order to support their children. They described experiencing emotional distress and traumatisation (Manion et al, 1996), and like those parents working with

Hildebrand and Forbes (1987), they sought help to resolve their own feelings, including anguish, guilt or self-blame, as well as to understand and support their children. In viewing commonalities in interviews, however, it is important not to lose sight of the unique characteristics of each account. Parents may have had different sources of stress, and for those responding it is important to recognise the different conversations required to ensure that a service meets individual needs. Practitioners with knowledge of parental reactions to child disclosures of sexual abuse may be tempted to make assumptions about what stress means to parents, rather than taking the time together to gain understanding and co-construct healing stories with carers and parents, a process which represents understanding as a "*relational achievement"* (Gergen, 2015: 128). In the context of the intervention, practitioners were socially positioned (Davies and Harré, 1990) as experts, as people who could provide help and answers to questions brought by carers. In this position, understanding carers' questions was crucial, and the relationship provided the opportunity for common understanding to develop. Interestingly, in other social relationships, Brenda's and Georgia's mothers were professionals, positioned as expert helpers, but were differently situated in relationship with their practitioners. They had not lost the knowledge or position they had in relation to others, but in the intervention they were situated as parents of young people affected by sexual abuse. People have multiple selves in social relationships. As Davies and Harré state:

> *"An individual emerges through the processes of social interaction, not as a relatively fixed end product but as one who is constituted and reconstituted through the various discursive practices in which they participate."* (Davies and Harré, 1990:45)

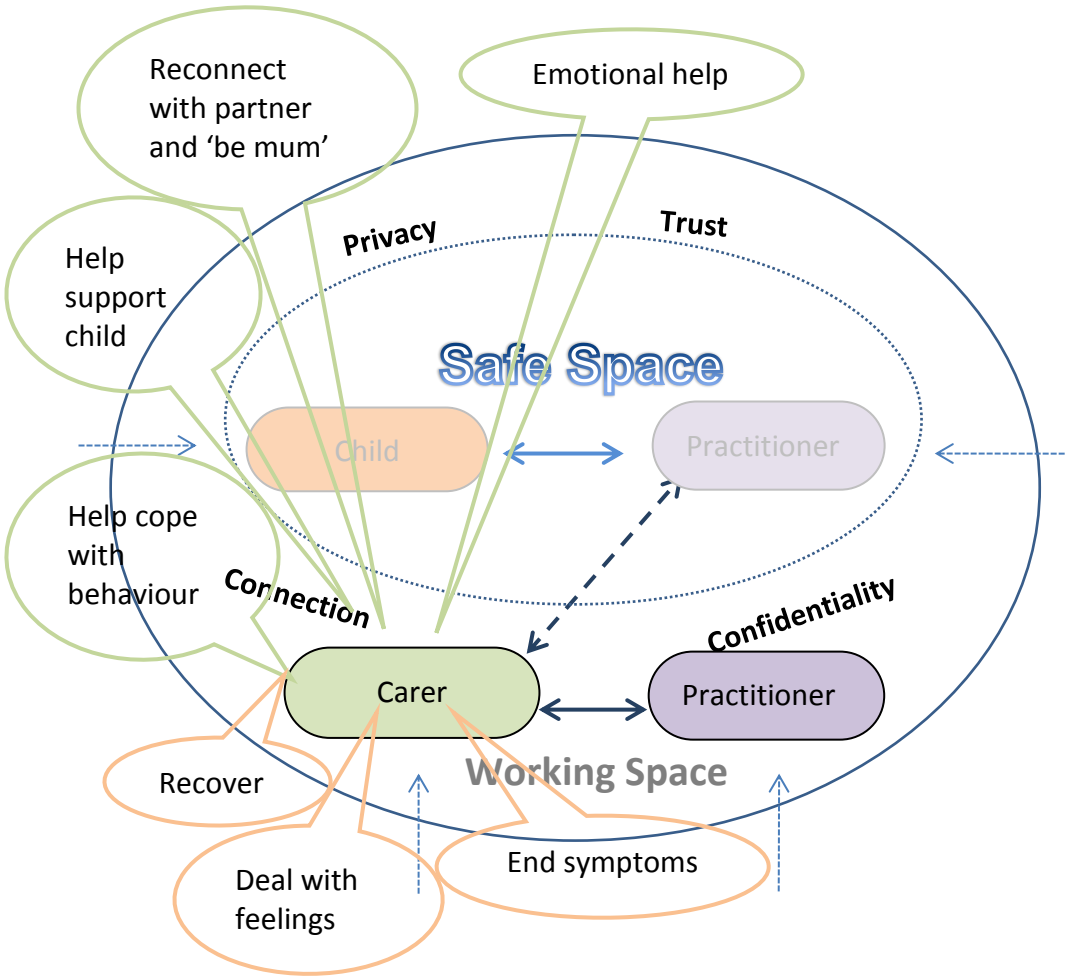
9.3.2.3 Summary

Parental concerns reflect the aims of the carer intervention and confirm anecdotally the high levels of stress found in the evaluation sample. Parents sought help and reassurance about their parenting, resolution of difficult and

conflicting feelings, and support to help their children recover in unusual and distressing circumstances, reflecting the reactions noted in previous chapters of feeling that their worlds had been turned upside down. Parents' aims were consistent with the areas of support identified by the intervention as potentially relevant to carers. Although goals developed in common areas, each parent's account was unique, with goals emerging and changing as engagement with practitioners continued. The following section explores how they viewed change both for their children and for themselves.

The themes developed in their accounts are presented in *Figure 35.* Parents' own goals are outlined in green; young people's are outlined in orange.

Figure 35: Themes developed from parent views on goals



9.4 Parental perspectives on change

Parents spoke of changes they experienced, and provided change stories about their children which are consistent with young people's accounts. Aside from Evelyn's mother, parents talked less about their own changes than about children's changes, but all changes they noted were positive. As the goals of parent work were to support their children through and after therapy, the way they talked about change is consistent with the structure and overall aims of the intervention. *Figure 36* shows the themes represented in parents' change statements:

Figure 36: Parents – Change Statements

Parental Change Statements	
Change in self	**Change in child**
1. New self-concept, feeling different about self 2. Being able to move on a. Unburdened b. Feeling lighter, freer c. Being freed to be mum 3. Learning	1. Comparison a. Daughter then/daughter now b. Needy then/confident now c. Improved relationships d. Back to herself/different child 2. Gradual progress 3. Saved/healed

9.4.1 Perspectives on change in self

9.4.1.1 New self-concept/identity

Interviews contained various examples of change through dialogues between worker and parents, but the clarity of change for Evelyn's mother, expressed by her and her worker is the most striking. Evelyn's mother reported what she felt to be profound changes in herself. She began to notice differences not long after she began her individual sessions:

> *"About like a few sessions in, I started thinking yeh, because I liked the feeling – obviously I'd cried, but when you leave it's like that started to feel good, like started to – realising that things were*

changing, and I started looking forward to it. Cus as difficult as it can be, it's for the best." [Evelyn's mother, 234-237]

Her account of change through conversations with her worker portrays the concept of change through relationship, and illustrates the process of creating new identities and stories. The traumatic impact of Evelyn's disclosure had adverse effects on many aspects of her mother's life, including her self-confidence, identity as a capable parent, health, and relationships. She had for years held an account of herself as a mother who failed to protect her daughter. Together, she and her worker constructed a different version, one that did not deny the reality of abuse, but which altered her role and restored her identity as a protective and capable mother. Through conversation, Evelyn's mother recognised that although she had not been present, she was not, as her head was telling her, responsible for the abuse, and she was a protective mother. The constructive process can be viewed in light of Parton and O'Byrne's description of the "*moratorium on mother-blaming by selecting facts that contradict self-accusation"* (Parton and O'Byrne, 2000:164).

The conversations served to reduce the conflict between what she portrayed as the heart and head messages. In dialogue with her practitioner, she altered the internal message to reflect a different and more positive reality:

*"Because I was saying I wasn't there for my daughter at the time, [**Worker**] added this little thing to the end of that sentence that I have to take with us, and every time I feel like that I just have to think it or even say it out loud, which is 'I wasn't there for her that one time when she needed me but I did everything right at the time to make sure she was safe.' So it's just sort of adding that small bit 'Yeh but you did everything that any parent would do, you just trusted the wrong person.'"* [Evelyn's mother, 110-115]

She described this as a "*seed planted*", the introduction of the possibility of seeing herself and being seen as a safe parent; reframing her account and adding an important new ending, which altered her self-concept of someone who was a "bad mother" and reinforced her faith in her "good" parenting abilities. Evelyn's mother recalled the practitioner's positive messages which

supported her efforts to see herself in a different way and emphasised her strengths:

> *"When all these things were coming out I think she realised 'Well you went through this with your daughter, and you did it by yourself', but I don't really ask for help outside of things so I think that's why she was a bit 'You've got to stop beating yourself up."* [Evelyn's mother, 181-185]

As with young people's change perspectives, it was important for the worker to emphasise Evelyn's mother's agency and ability to effect change. Accompanying her new personal account was a different understanding of trust in the context of exploring how her daughter's abuse was unexpected and unforeseeable.

9.4.1.2 Feeling able to move on

Parental reports of change included statements about feeling able to move forward with their lives. This theme resonates with comments provided in the *CFQ* about moving on or moving forward. Evelyn's mother's story incorporates a sense of being freed of the past and able to look forward, and she reported "*feeling lighter*" and less stifling as a parent. For Brenda's mother, the desire to be *"freed"* to be mother was progressed through the combination of her parent sessions and her daughter's therapeutic sessions. Being able to focus as a couple on moving beyond what had happened as well as receiving messages of their daughter's therapeutic improvements provided hope that life for all of them would improve:

> *"So we've come out stronger, but it's partly due to [**Agency**] taking on that role, saying 'We can deal with this, you deal with home.'"* [Brenda's mother, 265-266]

Brenda's mother was grateful that their practitioner was flexible enough to be guided by their wishes, and whilst acknowledging that there were issues that would perhaps never completely go, was satisfied that they had moved on. Unlike some parents, she felt that they finished at the right time:

> *“So we didn’t take up the offer of a final [session] because we’ve moved on. In many ways, it’s still there, but I think it always will be.”* [Brenda’s mother, 284-286]

Parents are offered limited sessions, and Evelyn’s and Chelsey’s parents were at first concerned about their capacity to maintain changes without support. Chelsey’s mother explained:

> *"It sounds really daft, but when the sessions ended I didn’t want them to end, I knew they had to, and I were ready, but it sounds really weird that, didn't it, because you'd think you'd want to move on, but because she'd helped me so much it was as if I was scared to let go."* [Chelsey’s mother, 134-137]

Everything had been helpful to her: the information, emotional support, and comfort had, in her view, led to changes in her which influenced other relationships, and she became more positive about managing on her own. Like Evelyn’s mother, Chelsey’s mother felt better, less burdened by strong emotions as her therapy *“got rid of a lot as well”* [Chelsey’s mother, 194]. Overall, she found "*the relationship I had with my worker helped me deal with my issues*" [Chelsey’s mother, 99-100].

Anya’s parents also expressed the view that they had been helped beyond their expectations. Anya’s mother took from her individual session the message: *“‘…that’s OK that you feel like that, but you don’t have to feel like that all the time’”* [Anya’s mother, 42-43]. These words acknowledged that negative feelings were common, they were not wrong, and that there were other possibilities. Her meeting with their practitioner inferred different meaning to the dialogues she and her husband had had in the context of a different kind of relationship. Their worker helped them think and feel differently about things, through the conversations they had in sessions:

> *“...you’d never come out, never sort of come out feeling worse, you come out ‘Oh actually, that was really good, cus we needed to go over that’, or ‘That was really good to have a chance to discuss that’, or ‘Actually that’s really good that [**Worker**] made us think about in that way.’”* [Anya’s mother, 305-309]

Looking back at the difference in their circumstances before and after the intervention, both parents attributed change to the time they and their daughter spent with respective practitioners:

> *"I think it's exceeded anything, with Anya with [**her worker**] and us with [**parent worker**] ... cus at the beginning you sort of think 'Ahhh' [indrawn breath] especially the way we were feeling when we all started last year 'Is this ever gonna - not come to an end - but are we ever going to ...behave normally again?' So the fact that we are makes me think well, yeh, the job was done well."* [Anya's mother, 283-288]

9.4.1.3 Learning

Anya's, Chelsey's, Evelyn's and Georgia's parents reported that they gained knowledge and information which was useful to them in their everyday lives. The theme of learning reflects the areas in the *CFQ* related to understanding about sexual abuse and children's needs which carers rated highly in *CFQ* question 1. Some knowledge related directly to feeling better about themselves because it helped them understand how sexual abusers groom adults as well as children, and how they could appear trustworthy yet be untrustworthy, as Evelyn's mother found. Other knowledge related to impacts of CSA and to parent-child relationships. Information that their reactions were "normal" reduced stress and anxiety about getting things 'wrong', and provided reassurance and a sense of belonging, of being like others. "*It was quite nice to have someone to say: 'No, that's perfectly normal and that's perfectly fine'*" [Anya's mother, 128-129].

Promoting thinking was "*useful*", as Anya's father pointed out. For him the dialogue, the "*good questions every so often*" helped them think. Anya's father found this enabled the couple to carry on conversations outside the sessions, plan how to proceed, and help Anya. The idea of starting thought processes or dialogues within the therapeutic space and continuing them in everyday spaces resonates with the concept of planting seeds, which both Georgia's and Evelyn's mother mentioned. For Evelyn's mother, it was the seed of possibility for changing herself. For Georgia's mother, it was about

the impact that she saw her daughter's worker having on her life and how much this assisted her mother in coping:

> *"...she made a massive impact on my daughter's life, she's planted seeds, she's planted seeds, and she's enabled Georgia to move through this, really difficult time, and I couldn't have done it without her, it's been teamwork."* [Georgia's mother, 271-273]

9.4.2 Perspectives on change in children

Parents views on changes they noticed in young people are reported here. Their perceptions of change are consistent with and expand on young people's views.

9.4.2.1 Comparison statements

Parents made a number of change statements which fit into the category of comparison. Comparisons included general changes and specific improvements, and involved considering how young people were "then" and "now". Changes were associated for parents with the intervention and their children's sessions, but also included acknowledgement of the parental role in supporting the therapy. Anya's father stated broadly that the "*results"* of the practitioner's support were clear:

> *"The results speak for themselves. Compared to the daughter we've got now, from the daughter we had at the lowest point, just a million times..."* [Anya's father, 429-430]

Both parents expressed that it was the way Anya and her practitioner worked together that was important. Parents recalled understanding why Anya's worker spent considerable time building the relationship with her, before what they described as "the real work" was done:

> *"...initially it was more about building the relationship … and then the real work, almost like [**Worker**] said, could start, once Anya wasn't in that [**school**] environment anymore. And you know, you sort of listen to all this, and you sort of think, 'OK, yeh, I can see that', but it really did work, didn't it, [**Father:** Fantastic] – it was amazing, then went*

from strength to strength and everything, so it was good." [Anya's mother, 423-427]

Anya's confidence, which had gone, was back, and she was "*well*" where she had been struggling and unhappy. Her parents also reported that it was Anya who recognised that she was ready to finish her sessions which they took as a sign that she felt stronger and more confident. Her mother described feeling anxious near the end, despite the obvious changes:

"I was a bit nervous about it before, once it was done, I could see for Anya it was like, that's been a real positive thing, out of something so horrible, comes something sort of really positive, so that's what we've always done, looked at Anya really and sort of thought, actually the change has been amazing, and so you know, you can't argue with that can you." [Anya's mother, 450-454]

Changes for young people and parents were connected. Improvement appeared contagious, and like Brenda's parents who were encouraged and felt better because of her progress, Anya's parents could compare the desperation they felt at the stage of referring Anya to their relief and hope at the end.

Other comparison statements were about specific changes which parents observed. Chelsey's mother observed positive changes in Chelsey's moods, noting that every time she came out of a session with her worker she looked "*happy":*

"*Chelsey would come out of the sessions, and you could tell from the day that she come out she were different, she'd be smiling, she'd be happy, whatever she'd done in that room, did work wonders."* [Chelsey's mother, 241-243]

She suggested that the effect was gradual and irregular, and that the *"happy"* effect wore off after a few days, but would return following the next session. Improvement was progressive, until ultimately Chelsey seemed to go "*back to how she was":*

"Her behaviour changed, and her attitude changed, the nightmares weren't as bad, and her whole well-being changed, she went back to

how she was, and I could notice the difference that way." [Chelsey's mother, 293-295]

Georgia's mother summed up Georgia's change as from "*needy"* to independent and confident:

> *"She's growing up into a young lady. We have blips, now and again... In the beginning she was extremely needy, the work with [**Georgia's worker**], and me working alongside her as well and our working together as a threesome, I could watch her change and grow, her worker said the same. She said exactly the same – 'She's not the same young lady that when I, that when we started working with her'. She handles situations better."* [Georgia's mother, 160-165]

Her description, with references to growth and maturity, suggests that change over time may be developmental as well as associated with therapy, and is consistent with Georgia's account of how she changed. Given the common purpose of helping Georgia, the sense of partnership, regular communication about progress, and conversations between mother and daughter, agreement in change observations by all involved is no surprise.

Evelyn's mother described Evelyn as a "*different child"* at the end of her sessions, and like other parents, recognised her own part in supporting change. She became a child who was a *"different person, you know, she's living a different life"* [Evelyn's mother, 143]. Looking back, it appears Evelyn's mother had constructed an account of change over time including the change from a child who just seemed to get on with life into a child who was struggling. She could place the changes which she associated with the intervention into this narrative:

> *"She used to be quite frustrated and just not know why, when she was confused and started to grow up and understand things, and her frustration was massive – so she used to just take things out on me, cus I'm the one that's here … but once this all happened there was none of that there any more, like she got rid of it. So I feel like a lot of that frustration and anger had gone. And I can see it in her face as well, she was just a lighter person, so if anything, it made her even more closer."* [Evelyn's mother, 252-260]

Making her "*more closer"* indicated improvement in relationships with others in connection with the work done within the therapeutic relationship. Where her mother saw some of Evelyn's relationships as troubled, she noticed a change by the end of therapy. Other parents observed similar improvements. Darcie's foster carer for example, noted that Darcie was finding being with other people easier and less stressful since the intervention. It particularly affected their relationship, and "*strengthened their bond"* [Darcie's carer, 432]. In a statement about differences that she observed by the end of the intervention, Darcie's carer gave her view of the relationship's contribution to change:

> *"Darcie sort of learnt the idea that what she felt and that was important in that total special uninterrupted space, it's given her the confidence to interrupt me, or come to me, or let other people know because she's found out how important that is, and that was really difficult for me to get over to her, I think it's much more concentrated in the therapeutic [space] and therefore it's had a massive impact on all your relationships I would say."* [Darcie's carer, 414-419]

9.4.2.2 Healing/saving statements

Parents also viewed change in terms of healing, saving or repairing. As mentioned previously, Evelyn's, Chelsey's and Darcie's parents perceived the parent-child relationships to have been repaired and improved through the young person's relationship with practitioners. Georgia's mother noted an improved child-parent relationship, and intimated at a healing process in two ways. First, she attributed considerable responsibility to Georgia's worker for helping Georgia overcome what both she and Georgia viewed as serious struggles when she said, *"I don't think Georgia would be where she is today without her"* [Georgia's mother, 31-32]. There is an implication in her statement that Georgia's worker helped prevent her from coming to harm. Second, Georgia's mother agreed that Georgia had been "*traumatised"* and that her practitioner helped her recover from traumatic experiences and regard herself more positively because, her mother said, "*she didn't like herself for a very long time*" [Georgia's mother, 227]. Despite her

professional knowledge, Georgia's mother did not have a relationship which could include that kind of support, in part because she believed Georgia viewed her as "*nagging and interfering"* [Georgia's mother, 65] and part of the problem.

Brenda's mother did not talk of a parent-child relationship needing repair – for them, the relationship Brenda had with her worker took over a role that her mother did not want. She did not want to be a therapist in her family, she wanted to be a mother. The intervention enabled her to do that, and it was healing for her and her husband, as she said, to "*lick our wounds".* For Brenda, the healing significance of the relationship appeared to her mother to be profound and life-saving: *"She says to me herself, [**Brenda's Worker**] saved her life, made her who she is"* [Brenda's mother, 155-156]. This statement echoed Brenda's comment that her worker changed her life. Words implying such deep feelings of despair are difficult for any parent to hear, even when they appear to have been resolved, but at the same time represent change and signify hope and future.

9.4.2.3 Discussion

The changes which parents experienced in themselves occurred through their capacity as humans to reflect, to critically analyse their situations and to choose to position themselves in societal discourses. Parents who were "*beating themselves up*" (Evelyn's and Anya's mothers) were, through conversations with their workers, able to take positions that were "*less personally damaging"* (Burr, 2015:142). What happened did not change, the circumstances did not disappear, but the women saw themselves as differently positioned.

The learning encompassed discovery of a different concept of trust. Trust depending on 'should' is unreliable; the idea that you "*should be able to trust your family members*" [Evelyn's mother, 607-608] is unsafe because trust is a relational experience that transcends family ties and other boundaries. Sexual abuse violates relational rules that suggest that others we know well

are predictable and stable. Gergen (2015:116) notes that people have "*potential for being other than what they seem",* in different circumstances and with different people. Adolescents are often different in the spaces they share with their friends than they are in parent-child relationships. It is possible to think of sexual abuse, particularly within a family, in the same way: an abuser in an everyday family space may present a public self which conforms to expectations of social and cultural roles. The same person contriving to be alone with a child may be, in Goffman's (1959) phrase, a person communicating "*out of character"* and presenting as someone different. The secrecy which characterises sexual abuse ensures that when the abuser-child space and the everyday family space coincide, the abuse remains hidden along with the abuser's other persona. There is, as Goffman suggests, a "*moral demand"* in social interactions which obliges people both to accept initial impressions and value others as they present, and to be the person that is presented (Goffman, 1959:24). Impression-management is a skill which abusers may use to conceal abusive behaviour, and with no evidence to the contrary, to appear trustworthy in the eyes of protective parents and carers. Breach of trust in sexual abuse has potentially profound and lasting impacts, which provide an undercurrent of pain in the accounts of parents and young people even in this small sample. It is a sad lesson to learn and, as Gergen points out in his critique of Goffman's view, serves to "*invite a deep skepticism about others and the self"* (Gergen, 2015:101). This is, however, how Evelyn's mother portrayed herself in her account, and it required a special relationship to rebuild her trust in others and in herself.

The power of knowledge is particularly apparent in parental discussions of change. Evelyn's and Anya's mothers could move forward feeling less burdened by guilt. Through sharing information about sexual offending and normalising parental responses, parents could alter perceptions about themselves, their roles as parents, and their understanding of their children's healing process. The changes they experienced helped frame their accounts

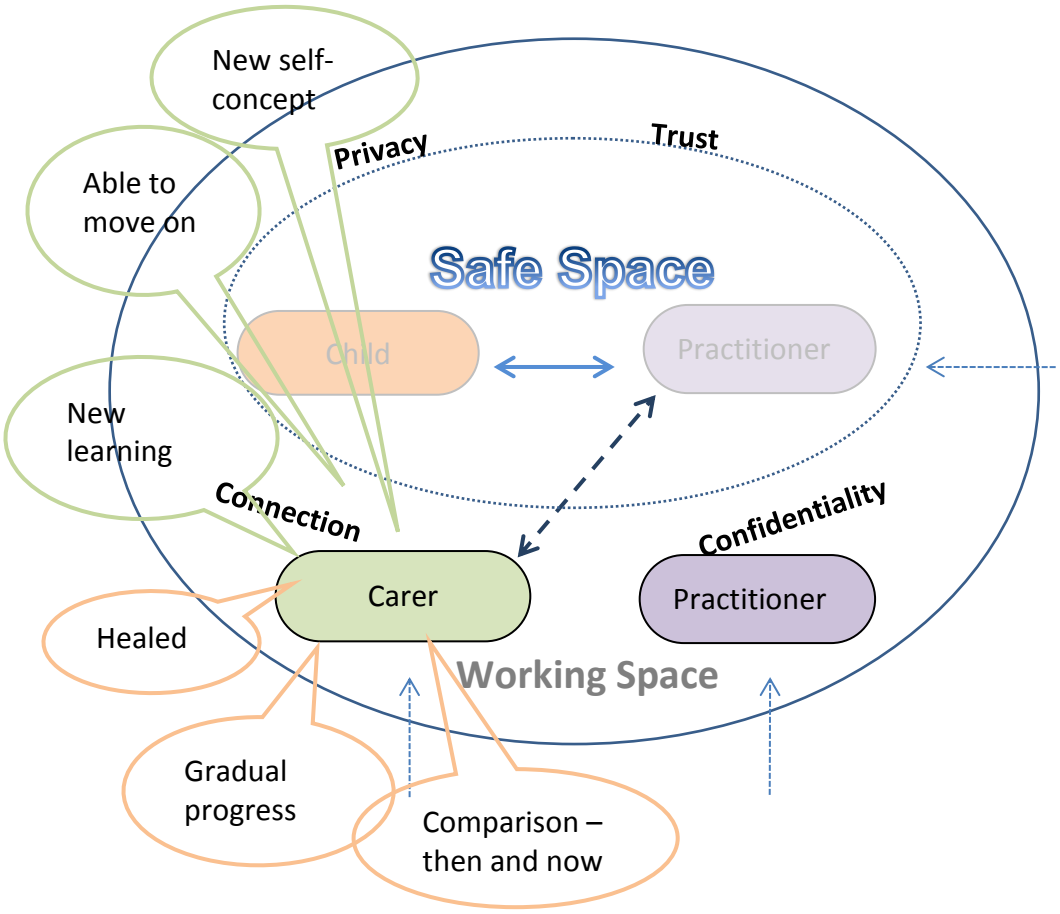
of changes they saw in their daughters, views which are presented in the next section.

Gergen's discussion of *"actionability*" is relevant to both parent and young people's change perspectives, particularly the comments related to everyday change. Gergen (2006) defines *"actionability*" as the "*street value"* attributable to change which begins within the therapeutic relationship. The value of considering the different vantage points on relationships and change is that "*actionability"* may become visible. Darcie and her mother both reported, for example, that what Darcie gained in the relationship with her practitioner – what Gergen (2006:52) might call the *"conversational resources generated within the therapeutic relationship*" – helped her transform the relationships outside the therapeutic space, the everyday spaces.

9.4.2.4 Summary

Parents provided fuller and more detailed accounts of goal and change perceptions than young people did. Possible explanations include speaking from a position of greater experience and understanding in the social world about parenting, relationships, help-seeking, and problem solving. Also, they may have felt more comfortable in interview talking with an adult who was also a parent. It is evident that parents noted significant and positive changes in their daughters following the intervention. Parent perspectives presented an intimate historical overview of part of their children's lives, which revealed the unique circumstances which make work with parents of abused children so variable. In addition, parent and young people's accounts were consistent in their emphasis on positive change, on improved relationships with others, on behavioural improvement and emotional recovery. The themes developed in their accounts are presented in *Figure 37.* Parents' own goals are outlined in green; young people's are outlined in orange.

Figure 37: Themes developed from parent views on change



The next section completes the picture, presenting practitioner perspectives on goal agreement and change.

9.5 Practitioner's perspectives – goals and change in parents

This section presents practitioner views on agreeing goals with parents and observing change. All accounts indicated agreement on goals, with, as earlier sections indicated, parents bringing their own issues and hopes to the relationship. The goals that practitioners felt they could agree with parents were confined to those which conformed to the intervention guidelines. Practitioners recognised that each family situation would be different, that parents would have varying expectations and hopes, and that change for them was likely to be associated with change for their child. In addition, as the intervention was new and represented, for some, a different model for working with parents of abused children, some workers expressed uncertainty about how much leeway they had to interpret the boundaries of helping parents with their own struggles.

9.5.1 Practitioner perspectives on goals with parents

Practitioner goals were aligned with the intervention guidance and workers used these as a starting point with parents. In practice, they saw goals developing in unique ways related to the nature of the working relationship and individual wishes of parents. For some workers, there appeared to be tension between the constraints of the intervention and what they saw as needs of parents to use the time to work on their own struggles. Conceptually they were able to incorporate the goals agreed with parents into the broad agency goals and appreciated that parents felt they needed to resolve issues they identified in order to support their children in therapy.

Goal setting varied from family to family, but the findings are presented under two broad aims of helping parents support their children according to agency guidance, and interconnected goals of helping parents with their own issues. The thematic categories are shown in *Figure 38*. Conceptually they are linked but distinguishable, with intervention goals representing a starting point and parent own goals identified along the way, as the relationship developed. In practice however, parent own goals were subsumed into the

goals set by practitioners as representative of the agency, as all goals related ultimately to supporting young people.

Figure 38: Practitioner goal statements - parents

Practitioner Goal Statements - Parents	
1. Starting points – intervention guidance	a. Understanding of child sexual abuse b. "Normalising" responses of children and parents
2. Goals within goals – helping parents with their own issues	a. Emotional distress, despair, hopelessness, isolation b. Wellbeing c. Self-blame, concerns about own parenting

9.5.1.1 Starting points – agency goals

Even as practitioners spoke of goals defined by the guidance, they were creating space for alternative plans to develop. Anya's parent worker defined her main goals to be that parents developed *"a capacity to support their daughter through the therapeutic process but… we remained mindful of their need for self-care"* [Anya's parent worker, 242-244]. These were agreed goals: she spoke of a "*shared vision"*, demonstrating collaboration to achieve a common purpose, plus a mutual understanding of the particular needs which parents expressed at the beginning. This example illustrates how workers were prepared to be flexible and guided by parents' definition of their issues. The worker spoke of presenting to parents her own belief in the importance of their well-being as they negotiated how she could support them with their school complaint. The limitations for her were clear – she was able to help them as long as their school goal did not "*overtake"* the primary purpose of parent sessions:

> *"…the key aspect of the work anyway, was always holding in mind, 'Don't forget, you guys have got to stay in there, in a good state if you like, to be able to see your daughter through her therapeutic process.'"* [Anya's parent worker, 68-71]

Chelsey's parent worker recalled explaining the purpose of the parent service at the beginning of their sessions. She described the goal in general as "*resourcing people, strengthening positive stuff that they've got*" [Chelsey's parent worker, 184] and specifically for Chelsey's parents to "*understand Chelsey's behaviour better, and understand what was driving it*" [Chelsey's parent worker, 335-336]. Like Anya's parent worker, she set limits early on but recognised in retrospect the difficulty of restricting goals whilst in a relationship where her approach offered a space for people to talk about what was most important to them:

> *"I said you know you'll be offered six sessions to look at psycho-ed basically and explained what that was, but of course it doesn't always go that way does it. And I know she had more than six sessions, that we had to discuss with my manager, and it just didn't feel enough, because it felt too big."* [Chelsey's parent worker 165-169]

Her solution was to negotiate additional goals which were consistent with the service's purpose, and additional sessions to work on them.

Brenda's parent worker described his view of agency goals but added that he wanted to find out what her parents wanted in the time they had:

> *"...trying to help them in essence with their relationship with their daughter who has been through sexual abuse… As I understand, that's the kind of goals that the guide sets, so we sort of spoke about that – but I wanted to try to find out from them what they wanted from it, realistically, what I could realistically do. I wanted to see what they – they knew what I was, when they first came they knew what the carers sessions were for, they knew they weren't counselling sessions, yet they chose to do them, so I kind of wanted to help them think about that."* [Brenda's parent worker, 148-156]

The worker started with the aims made explicit in the guidance, but goals they ultimately established came from parents. The development of the worker's role as "*witness"* emerged in collaborative interpretation of the concept of support.

9.5.1.2 Goals within goals

Practitioners and parents agreed goals within the parameters set by the intervention guidance. These were like goals within goals, about specific struggles which parents identified. Anya's parent worker, for example, acknowledged that sorting out the "school issue" was enormously important to parents and agreed to support them in pursuing it. The issue added a layer of complexity to her work, and, as she put it, "*another dynamic that needs to be taken into account"* [Anya's parent worker, 47-48]. Chelsey's parent worker recognised the need to be flexible and creative in her work. The additional sessions she negotiated were required because of the time it took to build trust, and Chelsey's mother's experience of distress. In order to set realistic goals, the worker said she asked herself "'*What can I achieve in this time that's gonna leave her feeling better, and not undoing anything that I can't put a lid back on'?"* [Chelsey's parent worker, 204-205] Like Brenda's parent worker, she was concerned not to agree unrealistic goals with Chelsey's parents. She noted the internal conflict she experienced in balancing what she saw as imposed requirements with the parent's need:

> *"...if the symptoms can be reduced by working on whatever's gone on, let's do it. So that's where I got to with [**Parent**] really, cus I was really torn about sticking to the protocol if you like... And it's a real – I don't know about dilemma – sort of conflict, something that needs, you know, I have to discuss, and reflect on, and decide."* [Chelsey's parent worker, 194-199]

It is interesting to contemplate the idea that there might be something in a protocol which practitioners believe inhibits them from agreeing on goals they think might best help people. The goal within the wider goal was agreeing to work in a specific way on an issue identified by the parent. The practitioner's dilemma was in offering a therapeutic technique in a non-therapeutic service: "*There was that dilemma, "'I know it's not therapy but I've got a tool here in my box which might be really helpful'*" [Chelsey's parent worker, 171].

Evelyn's parent worker recognised mother's commitment to having support of any kind from the beginning:

> *"That determination that was there just right from the very moment we first met, that it was 'I want to make a difference for my child, I want things to be different' and that she was willing to do, you know look at some really painful things to help that happen."* [Evelyn's parent worker, 394-397]

She saw the work as progressing through a succession of what can be conceived as small goals within the wider goal of wanting things to be different for Evelyn. Establishing trust was a goal, undertaking socio-educative work followed, and agreeing to spend time on the "*painful things"* was another. The space belonged to Evelyn's mother, and her worker perceived it as a place where she could bring whatever she wanted to talk about. Helping the parent to be stronger and more positive would, in turn, help her support her daughter.

Parent workers also saw as goals providing hope for the future; helping parents think positively at times when they felt despairing; feeling less alone and isolated with their struggles. These goals appeared to stem from the empathy and care reflected in the approaches of all practitioners interviewed, from knowledge about how CSA affects parents, and from an understanding that for parents to look after their children they need to be well themselves. Evelyn's parent worker felt for her when they first met because *"she just seemed so small and low"* [Evelyn's parent worker, 292] and she wanted to help her look towards the future. Brenda's parent worker was struck by Brenda's mother's distress and described a goal of providing "*hope and warmth"*. His view of helping initially differed from Brenda's mother's goal, and he adapted his approach accordingly:

> *"I remember her saying at one point that she felt I was asking her to swim before, before she could – when all she could do was float. I suppose there was that sense in me that we'd only got eight sessions, I need to try and be encouraging some help, trying to help things along a bit, but actually what I needed to do was just sit back more, that's what I found."* [Brenda's parent worker, 368-372]

Goals also explicitly included providing hope and optimism. Workers for Brenda's and Georgia's parents were specific about the importance of opening dialogues of hope in the relationships, and the changes they observed as a result. Georgia's mother's worker agreed with her that she did not need "*educating*", and focused instead on helping her look after herself so that she could look after Georgia. It was a goal of maintaining mother's mental health during a difficult time:

> *"...we felt that actually if she did that well, and contained her anxiety and kept her mood reasonably buoyant, that actually she was in a much better place to support her daughter through the work."* [Georgia's parent worker, 82-84]

He saw his "*prime role":*

> *"…to be to create some hope and optimism and create some room in her constructs of the world that actually there is some possibility for change, and for things we don't know about yet."* [Georgia's parent worker, 54-56]

His focus was on what "*we*" (collaborative) could do to be helpful to her daughter, and described the importance of introducing change as inevitable, saying to her "'*So what's it going to be like when change has happened' and 'What will you be doing when this has happened?'"* [Georgia's parent worker, 120-121] When talking generally about helping parents of abused children, he used the metaphor of "planting seeds" to describe presenting possibilities for being different. His role included *"inspiring"* people, and he viewed building a relationship in which possibility for change was recognised to be essential:

> *"...for me, it feels like you have to inspire people, and you can't inspire somebody if they haven't got a relationship with you."* [Georgia's parent worker, 522-523]

9.5.1.3 Discussion

The beginning of the section mentioned the tension for some workers in accommodating the goals they set with parents within the remit of the intervention. Practitioners resolved tension by interpreting the language of

the guidance in their own ways, in dialogue with parents, and in conversations with supervisors. This was possible because they accepted that the concept of "support" has multiple meanings and that for any service to be effective there needs to be a common understanding of what effective "support" means. As Gergen (2009:33) wrote, we are both "*nurtured"* and "*imprisoned"* by the conventions of language. In Brenda's parents' case, the practitioner became aware that his interpretation of support and theirs were different, and they needed to find common ground. As a therapist, he accepted that their idea of the support they needed was the most important, and although he was unsure if what they agreed fit the guidelines, he argued for it. Chelsey's mother's practitioner was not sure that it was permissible to use what she described as a "therapeutic" technique if the service was not "therapy". Anya's parent worker negotiated extra sessions by noting that there were two parents, and they needed more time. Thus practitioners interpreted the guidance to suit what they saw as the demands of each case.

9.5.2 Practitioner perspectives on change in parents

By the end of the intervention, all practitioners thought that parents' situations had changed for the better. In some cases, workers had noticed striking changes; in others changes were more subtle. Because parental goals varied considerably and practitioners had far less contact with them than children's worker did, variation in their perspectives on change is not surprising. Two categories of change statements are discussed (*Figure 39).*

Figure 39: Practitioner change statements - parents

Practitioner change statements - parents	
1. Shift in outlook	a. Hope b. Positivity about the future c. Leaving the past behind
2. Self-concept/identity	a. Parenting confidence b. Good mother image

9.5.2.1 Shift in outlook

Practitioner statements about parents moving forward acknowledged the difficulties that parents of children affected by sexual abuse face and indicated that they witnessed a shift towards the future. Examples include Anya's parents' believing they would be a normal family again, Evelyn's mother wanting to leave the past behind, and Brenda's mother wishing to just be mum.

Brenda's parent worker was reflective on the topic of change. He thought that whilst the sessions and therefore the working space represented an important "*catalyst"* for change, he was uncertain about the significance of his role in facilitating change. He provided space, encouragement, and hope. Change that he noticed was about hopefulness, and what he thought provided parents with the greatest hope was their daughter's progress:

> *"...by about the 4th session I remember Brenda's mother saying something which for the first time I thought sounded vaguely hopeful - I was really amazed by that! and she really seemed to change quite a lot, and having noticed changes in Brenda, and picking up on those, and seeing how quickly she was growing and developing and getting back to normality and feeling really good about that."* [Brenda's parent worker, 116-120]

His reflections are consistent with Brenda's mother's account. Her interview describes a sense of moving on because the service as a whole was supportive, and any news of her daughter's therapeutic progress served to reinforce this change.

Evelyn's parent worker presented a poignant picture of how she saw Evelyn's mother's predicament and then her shift towards thinking about the future. In the beginning, she said,

> *"...she was so like she was in the present, she felt she had to be there totally with her daughter, and not give herself any time whatsoever, and then it was kind of working through that 'Well, what now?' because Evelyn was starting to move on."* [Evelyn's parent worker, 148-151]

Change promotes change: Evelyn's mother's worker perceived her as having filled her life with her daughter, and as now wanting to fill the space that Evelyn growing and changing created. This was an interpretation derived from the way Evelyn's mother described herself and her construction of her role as mother. Moving past guilt and blame was a challenge which she brought to the relationship with her worker, so their conversations focused on the possibility of seeing herself in a different way. The worker said that "*by the end of it she just seemed really positive and had the energy to make a change in their lives, and was happy about the changes*" [Evelyn's parent worker, 291-294].

Evelyn's mother's initial statement of her reality started with the words: *"'I wasn't there when she was scared'*" – a powerfully negative statement – but through talking and thinking about her feelings, she and her worker created a new statement:

> *"We sort of unpicked that a bit, and looked at the evidence for and against it, and she kind of came up with another, like more balanced thought of 'I wasn't there when she was scared, I know I wasn't there when she needed me, but I did everything I could to keep her safe'".* [Evelyn's parent worker, 94-98]

Interestingly, each person credited the other with creating the second part of the sentence, as if in the collaborative process individual identity with or responsibility for the solution was unimportant. Evelyn's mother said in her interview that she carried this statement with her to repeat when she needed to. In the beginning she was stuck in the first half of that sentence and her worker saw her task as helping her find a way out. In developing the second half they constructed a possibility of a more balanced and positive reality. In the practitioner's eyes, their relationship was a starting place for something new, an opportunity to leave the past behind, a "*springboard"*:

> *"...just thinking about relationships generally giving you that safe space to then go off and do things, if you know what I mean, it was like a springboard almost."* [Evelyn's parent worker, 367-369]

9.5.2.2 Self-image/identity

Both Chelsey's and Evelyn's parent workers perceived changes which corresponded to the parents' own views. Both practitioners used the word "*stronger*" to describe the difference in how parents appeared between first meeting and end of the intervention; both felt that for these mothers some faith in their own parenting had been restored, increasing their confidence. Chelsey's parent worker described Chelsey's mother at the end as:

> *"...more sure of her own abilities as a parent, that confidence in, 'Yeh I do know what's best for my daughter' came through. And that she was a good mum."* [Chelsey's parent worker, 443-445]

Evelyn's parent worker had similar views. She noted how different Evelyn's mother's thinking about herself and her life was at the end of their sessions, and how she had thought she was "*happy with how her life was at that point in time"* until she began to talk about how different things were at other times and how much she wanted life to be different now. Comparing the past, the present and the future were all possible through dialogue between worker and parent. Her practitioner recalled the ending, commenting "*when we got to that end point, she was like 'Yeh, me and Evelyn are OK, we're ready to do it ourselves' kind of thing"* [Evelyn's parent worker, 181-182]. When someone says '*we are OK, we can do this now*', it is an indication that change has occurred.

Georgia's parent worker referred to change less confidently than Georgia's mother did, although this may have been due to the challenge of recalling details. Where he discussed how capable and resilient he found her, she talked about how reassured she felt by his confirmation that her parenting skills were sound, and how useful she found information he provided. If one of their shared goals was to help her maintain her resilience and energy, then her account suggests that they succeeded.

9.5.2.3 Discussion

Both parent and practitioner accounts reference the characteristics and impacts of CSA which conspire to silence and isolate victims and families. To appreciate the meaning of the identity shifts referred to above this discussion refers to a previous theme of "*bad mother stories"* (Chapter 7). Among the myths and social constructions about CSA are those that afford responsibility to keep children safe and well (Croghan and Miell, 1998) and to be present and monitoring their safety at all times (Kitzenger, 1997) primarily to mothers. Georgia's and Anya's mothers alluded to feelings of responsibility for somehow letting their daughters down, and Evelyn's mother was open about her guilt for not being there. By focusing conversations on the future and on their strengths as parents, practitioners helped parents think differently about themselves in the context of their child's abuse, and to look forward. The impact of ensuring that parents knew that about their children's progress was apparent in practitioner accounts.

For mothers in this study who felt that they had somehow failed to live up to the ideal of "good mother" to have redefined what were previously perceived as "failures" as not their fault represents a significant shift. It may be double-edged however, because the ideal still exists and the shift may represent only a repositioning within what are accepted gendered norms of parenting. In other words, it is important to recognise, as Evelyn's mother said, that they did "*everything right at the time to make sure she was safe"* [Evelyn's mother, 113-114]. This account moves the blame from the parent to the abuser and represents a goal of her sessions. However, it begs the question about the underlying cultural assumptions which serve to shift the blame from perpetrators to poor parenting, or particularly "bad mothers". McLaren (2012) explores this experience in relation to women, explaining how in intrafamilial CSA heteronormative power:

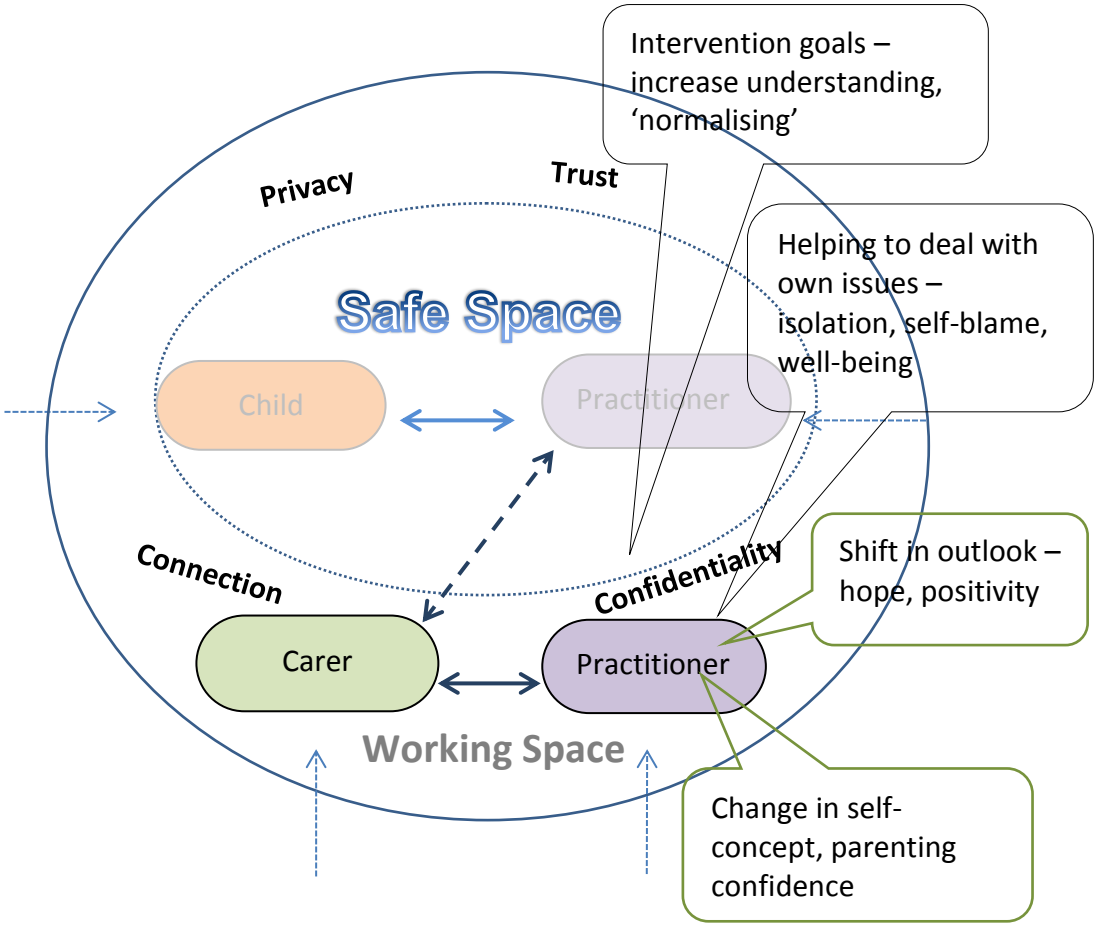
> *"...has the potential to shift the responsibility and blame away from perpetrators and towards the 'bad lover', 'bad woman', or 'bad mother'... which further blames these women and silences them"* (McLaren, 2012:440).

The direct contribution from fathers in this study was too limited for any discussion about how men might change or benefit from engagement in the intervention. Family impacts of CSA are not limited to mothers (Dyb et al., 2003; Manion et al., 1996; Trotter, 1998) but men may have different narratives and bring different issues to helping relationships. The topic is beyond the scope of this thesis except to note that this is an under-researched area deserving of attention.

9.5.2.4 Summary

Figure 40 shows themes developed in practitioners' accounts on parental goal setting and change. Goal themes are outlined in black; change themes in green.

Figure 40: Themes in parent practitioner accounts on goals and change



Practitioner accounts emphasised the variability of goal setting with different parents. Workers interpreted the issues which parents brought as related to developing their capacity to best support their children, and they generally agreed with Anya's parent worker that in order for parents to support young people they needed to have confidence in themselves and their parenting. Common in the voices of parents and their practitioners is the theme of reducing isolation by enabling parents to enter into dialogues about things they could not talk to anyone else about. Practitioner goals for Chelsey's, Evelyn's, and Georgia's parents included normalisation of their experiences, validation of parenting skills, and reduction of isolation through providing a place where they could talk openly about sexual abuse. Workers perceived that parents' feelings of guilt and blame about children's abuse prevented them from seeing a way forward.

Practitioner perspectives on change in parents were variable, but generally consistent with parent views. All parent practitioners saw helping parents resolve their own issues of trauma and/or guilt about their child's abuse as part of their role, but determining the extent to which this was required and the manner in which issues were addressed was decided collaboratively. Where there appeared to be a mismatch of goals, as in Brenda's parent's case, practitioners and parents negotiated. Workers expressed some concern that the new guidance might hinder their success in accomplishing agreed goals, yet they were able to report positive change. Evelyn's parent worker summed up the shift in both outlook and self-image that she observed working with Evelyn's mother. Her account illuminates the process of change through relationship and dialogue and the concept of actionability:

> "*At the very end it was actively doing the stuff that we'd been talking about, feeling strong enough to do it herself and not need to kind of have the debriefs or the talks about it that we'd have in the sessions, and sort of concrete plans, like to be able eventually to repay some debt kind of thing, actively doing that, to be able to achieve that end goal, so that action phase kind of thing which was brilliant, and feel ready rather than fearful of the future, just feeling there was an opportunity and positive about the future, and just that the abuse was*

in the past, and being able to leave it in the past rather than being in the present was a big, big change." [Evelyn's parent worker, 348-355]

9.6 Chapter summary and conclusion

> *"Like talk, change is endless, constant and inevitable.* (Parton and O'Byrne, 2000:59)

Participants in this study provided an overall picture of the kind of collaboratively constructed "*therapeutic reality and solutions"* offered by O'Hanlon (1992:136). Whatever the young people's and parents' circumstances, whatever the therapists' approaches, relationships involved conversations in which parents felt able to state their own goals and hopes for themselves and their children. Although none of the parents described their sessions as "therapy" in the formal sense, the "therapeutic" quality of their meetings in the sense of being helpful or healing can be seen in their accounts of relationships with workers and experienced change.

In the previous chapter young people talked about themselves as different and their lives as improved. This chapter provides additional detail and perspectives of parents and their workers on young people's change accounts. Parent interviews demonstrated the strength of their commitment to obtain help for their daughters, and the positive changes they witnessed. Parental goals were primarily related to supporting their children: as Brenda's mother said, it didn't matter that she had to be selfish and demanding to get the help her family needed. Through parent and practitioner accounts, a view of parents who also experienced change in relation to their children's changes is seen: as their children progressed, so did they. Practitioners used information about young people's progress to bring hope to their work with parents. Young people's relationships had a ripple effect on relationships within the family and beyond: as a systems perspective would predict, change in one family member had an effect on others.

The final chapter summarises the findings as they address the research questions, recalling how they complement the findings of the Evaluation. It includes a reflexive section which makes explicit the researcher's own position in the process and the analysis retrospectively, and provides a final relational perspective in a different voice. Finally, it offers a conclusion and recommendations for further research and practice development.

10 Summary and Conclusions

> "*Am I safe? Can I cope? Will I be accepted?"*
>
> "*I am here... I hear you ...I understand... I care."* (Landreth, 2002:177; 205-206)

The purpose of this study was to trace the path of relationships in a therapeutic intervention through the eyes of those involved to find out: what are the experiences of the relationships established in this intervention from the perspectives of the people involved? The research is informed by social constructionist thinking, theory related to sexual abuse and therapeutic relationships, and inspired by social work experience with families affected by sexual abuse. The perspectives provided by young people, their carers, and practitioners were thematically analysed using Framework Analysis. The study is primarily qualitative, but incorporates a subsample of TASC *(Therapeutic Alliance Scales for Children)* data and CFQ *(Carer Feedback Questionnaire)* data collected during the evaluation. These data were used to answer research questions, and to provide helpful context for the qualitative data. The structure of the findings chapters follows the conceptual definition of therapeutic alliance as incorporating a bond between therapist and client, agreement on therapeutic goals, and collaboration on tasks (Bordin, 1979), a definition which also underpins the TASC.

This chapter concludes the thesis by summarising how the findings respond to the research questions, offering a reflexive view of the research process, noting the strengths and limitations of the study, and discussing implications for practice and suggestions for further research.

10.1 The research questions

The overall aim of the study was to find out what the experiences are of the relationships established in this intervention from the perspectives of the people involved. This section reviews the research questions and summarises how each has been addressed.

10.1.1 Research question 1: From participant perspectives, to what extent to do practitioners establish positive therapeutic relationships with children and safe carers?

The quantitative and qualitative findings demonstrate that, overall, participants perceived the relationships between practitioners and children or parents to be positive. The quantitative data related to young people showed that they scored items positively and that scores mostly rose or remained the same between the first and second time scales were completed, indicating that not only did children rate their relationships positively overall, but they did so with consistency over time. The qualitative data provided insight into the meaning of positive ratings for individuals. Young people described how quickly their workers helped them to overcome anxiety about engaging with an unfamiliar person and process, and offered a picture of relationships which grew and strengthened, in which young people felt safe to work on their problems. Practitioner interviews provided views compatible with the individual young people with whom they worked, but from a reflexive, experienced, and professional perspective. They spoke about their genuine feelings of care and connection with young people and also of how they worked to ensure positive relationships, demonstrating their belief in the importance of creating safe relational spaces where they could help young people affected by trauma.

Parents also provided views of their children's relationships with therapists as overwhelmingly positive, and because their accounts came from a position of intimate knowledge of and concern for their children supplemented both young people's and their workers' perspectives in unique ways. Parents' views were influenced by their gratitude to the service as a whole and to their children's and their own practitioners.

Overall, parents described positive relationships with their own workers. However, context was important and relationships with workers varied considerably. Life experiences, individual circumstances, and the context of their child's abuse experiences influenced their approach to sessions and relationships with their own workers, and with their daughters' workers.

Although practitioners made some use of therapeutic techniques, these were not therapeutic relationships, and there was no corresponding quantitative measurement to contextualise the information they provided. Parent approaches to the carer intervention varied, and although all relationships with practitioners were good, descriptions of the nature and strength of the relationship differed. Parent practitioners' views corresponded with parent views, describing positive relationships with some similarities in relationship building and techniques to those described by their colleagues who worked with children.

10.1.2 Research question 2: How are the concepts of bond, collaboration on therapeutic tasks, and agreement on goals manifested in relationships in this study?

The concept of bond is addressed primarily in Chapter 6, which considers how young people, parents, and practitioners build relationships in which they can work together. The scores on the bond scale indicate that young people in the TASC sample liked their workers, felt they were on their side, and enjoyed spending time in their sessions with them. Young people's interviews supported findings of the scale, as individual young people made comments about growing to like their workers, feeling that their workers were on their side, and looking forward to their sessions. The qualitative data highlighted the importance of the bond in creating a space where young people felt safe. The building of trust was, for all young people, a key element of creating a bond, a finding that was also reflected in parental perspectives on their children's therapeutic relationships. The empathy and care that young people felt in the company of their workers encouraged feelings that their workers were trustworthy. Young people also focused on confidentiality and privacy, represented as feeling that whatever they shared with their workers was protected unless their safety was at risk. They described workers as, for example, like a friend or like a sister and the work spaces as familiar, like home, illustrating their comfort with both the person and the environment.

Workers also rated corresponding bond items highly, showing coherence between their views and young people's. Practitioners demonstrated genuine feelings of care and empathy towards children, and were motivated to make and maintain a connection. As professionals experienced in working with people affected by sexual abuse, they recognised the significance of safety and trust, and their accounts reflect the value of providing spaces where children could experience safety, familiarity, comfort and privacy.

Parents observed the bond between children and workers and believed it contributed to their children's recovery. When parents talked about the significance of the "relationship" for their children, they referred to the sense of trust and safety they witnessed between young person and worker and their view of the need to establish the relationship in order to work with trauma. In terms of relationships with their own practitioners, parent reports varied. Parental accounts did not emphasise the need for a therapeutic bond or safe spaces and trust equally, although the relationships they described were "safe enough" for the purpose of their intervention. For two parents who reported serious struggles with the emotional impacts of their children's abuse, forming a trusting bond with their workers was important. They found the entire experience with their workers somewhat unexpected, and intense and beneficial despite its brevity. They valued the understanding, non-judgmental attitudes, and empathy shown to them at a time when they felt vulnerable and in need of support.

Chapter 7 examines how young people and their parents worked collaboratively on tasks and activities in the spaces they created with practitioners. High scores on the task items of the TASC indicate that young people did not find it hard to work on problems, found the amount of time devoted to working on problems was not too much, felt that they worked well with practitioners and worked towards making changes in their lives. Practitioners' scores were similarly positive, indicating that they recognised young people's engagement with the therapeutic tasks. The qualitative data shed light on the process underlying the scores. Young people expressed

views that the safety of the therapeutic space and their connections with workers helped them be open and honest and express their feelings in ways they could not or did not feel safe doing in their everyday spaces, which in turn helped practitioners open conversations on how to work on problems. Young people reported that practitioners gave them choices, listened to their stories and views, took them seriously and did not judge – all aspects of the relationship which encouraged their participation. Young people also valued feedback from their workers on progress. Practitioners reported accepting young people's reality in order to demonstrate that they were on their side and would, as one young person said, '*fight their corner*', without being judgmental. Workers described taking the lead from young people rather than pursuing worker or agency agendas, and providing choice about the pace and content of the work, which effectively restored a sense of power to young people who had experienced powerlessness in abuse. Practitioners listened and paid attention whilst working, related reflective accounts of their understanding of individual needs and wishes, and incorporated fun and humour into the work. Tasks varied widely and included talking, playing, writing, art and activities. There is symmetry in the views of young people and practitioners which evokes, even in retrospective accounts, a sense of movement within the relationships in response to one another.

Parents described various ways of working collaboratively, and noted their capacity to choose the focus of sessions. Tasks included delivering and receiving information; talking about problems; focusing on relationships; expressing and dealing with emotional issues. Important for all parents was hearing about their children's progress. Feeling that they were not judged by workers or blamed for their children's abuse was a feature of four of five parent accounts, and their workers responded to concerns by providing reassurance about parenting and "normalising" their experiences. Like young people, parents reported that they struggled to talk to people in their everyday spaces, so valued the relationship with practitioners to reduce feelings of isolation and increase understanding about the issues they and

their children faced. Practitioners were aware of the constraints of the carer intervention, and whilst being flexible and responsive to unique needs and wishes of parents, also limited their expectations of the relationships with parents accordingly.

Goals are discussed in Chapters 8 and 9. All accounts are retrospective, meaning that conversations about goals in interviews occurred after change took place, which colours memories of goal-setting. Interviews with participants indicated that goal-setting is not always a clear cut process, as goals tended to develop in interactions within the relationship and even goals which appeared to be identified early on were refined and developed as time went on. Defining goals was not easy, and it was not until therapeutic relationships were established that young people understood that they had choices and could decide what they wanted to work on as well as how. Goals thus evolved over time in conversations and activities with workers. In some cases, young people expressed a general wish to change the way their lives were. In other cases, however, young people talked about wanting to resolve specific symptoms, and practitioners confirmed that some young people had definite ideas from the beginning about what they wanted to talk about in therapy. It was in dialogues with workers in the safe space that goals were consolidated.

Practitioners had therapeutic goals in mind based on individual assessments with young people, informed by expertise in CSA impacts and symptoms, and underpinned by professionalism and agency aims and objectives. Regardless of therapeutic approach, all practitioners described child-led practice so worked together with young people to define problems and paths toward change. Practitioner goals included helping young people to reduce the traumatic impacts which interfered with relationships in their everyday lives, which matched young people's goals to reduce symptoms.

Parental goals varied, but shared a common overall focus on reducing symptoms and achieving best possible outcomes for children, goals which coincided with practitioners' aims. Because the objectives of the carer

intervention were clearly defined as supporting children's therapy, parents generally did not expect to get anything out of it beyond information, support and advice, so did not engage with other goals in mind. In some cases, however, in conversations with their workers, they identified abuse-related issues affecting them, a process of evolving and refining goals similar to the pathway described by young people and their workers. Practitioner views coincided with parents, and their descriptions of goal-setting demonstrated responsiveness to parental requests, needs and circumstances.

10.1.3 Research question 3: How do therapeutic relationships between children and practitioners develop and change during the course of the intervention?

All young people described positive relationships developed over time. They were dynamic, representing a process rather than an event, so whilst measuring alliance at points in time is useful, an overview illuminating patterns in relationship development and change provides a different kind of knowledge. Each young person's account created a picture of a safe relational space, co-constructed with their worker, where each young person experienced trust, confidentiality and privacy, empowerment, and choice and control. From a starting point characterised by anxiety and uncertainty, all found a space where they could feel comfortable, safe, and relaxed with someone who cared, listened, and understood. The feelings of comfort within the space enabled dialogues – variously focused and direct; developing through play or activities; difficult; enjoyable – which opened possibilities for different ways of being. The fluctuations in relationships were portrayed by practitioners as "blips", wobbles" or "bumps", some of them precipitated by events outside the relationship and some by work within it. In no case did practitioners or young people report serious ruptures in the relationship. Young people were given choices rather than commands, and experienced patience rather than pressure. The ending of the relationship with their workers, tinged with anxiety and sadness, also represented a

beginning as transformations to their lives outside the therapeutic space felt positive.

10.1.4 Research questions 4 & 5: What child, practitioner and carer characteristics are associated with establishing and maintaining an effective relationship in therapy? What patterns can be observed in the development and maintenance of relationships?

As these two questions relate to the building and maintaining of relationships, they are summarised together. Young people described positive characteristics of their workers which they perceived as helpful in developing and maintaining their relationships. First impressions were important. All young people felt anxious or nervous at first, but noted that in a short space of time they perceived their workers as nice, warm, comforting, friendly, funny, calm, or relaxed, which helped develop the sense that these were safe people. Although the length of time to settle into a relational pattern and understand mutually agreed roles and routines varied, young people gradually felt more relaxed and unpressured, and said that they were reassured by practitioners' manner and by their explanations of confidentiality, privacy and how they could help. The connections established were consolidated by practitioner actions and characteristics including listening, caring, understanding, reassuring and being trustworthy. The picture portrayed by young people is of practitioners who were tuned in, interested, and paying attention to them.

Practitioners represented a range of backgrounds and therapeutic approaches but for each the therapeutic relationship underpinned the process. Practitioners began relationships with an understanding that theirs was a position of expertise and knowledge, and that young people traumatised by sexual abuse would need to experience safety and trust in the relationship before they could talk about problems. They sought to present themselves as reliable, trustworthy, calm, empathic and reassuring, characteristics which young people described positively and to which they

responded. Practitioner descriptions of relationships indicate how thoughtful and reflective they were throughout, and how well they got to know young people, monitoring how they were, noting and responding to small changes, ensuring safety and well-being. Workers felt that providing young people with choice and a sense of control over the process and accepting their reality were important in building trust and sustaining young people's engagement. They also revealed themselves to young people through talking and chatting, which both found helpful. These moments represented less intense but valuable relational exchanges which perhaps led to young people seeing their therapists as 'friends' and finding times when each could simply enjoy the other's company.

Although there were common elements and characteristics noted by young people and practitioners describing relationships, each relationship was unique. Practitioners found that relationships developed in unpredictable ways, ended unexpectedly, were interrupted by "wobbles", or alternatively were characterised by dramatic moments in the form of sudden shifts or breakthroughs. Because they could compare one relationship with another, stories of movement and moments within the relationship appeared in accounts of practitioners rather than young people, who were not asked to relate details which risked returning them to an emotional place of trauma.

As parent practitioner relationships were not therapeutic, a similar pattern of trust building and safety followed by trauma work was not anticipated. Nevertheless, parents described similar practitioner characteristics which they perceived as helpful in developing and maintaining a positive working relationship. Developing safety and trust appeared particularly significant in two cases of parents who felt otherwise unsupported in their distress. Parents valued professionalism, reassurance about parenting, and understanding of their situations, and felt confident that their workers were knowledgeable and experienced. In one case where parents did not initially identify such confidence, the start of the relationship was perceived by both worker and parent as shaky. Parents found overall that practitioners were

easy to talk to, comforting, flexible, supportive and empathic and valued workers not judging.

Practitioners were careful to respect the boundaries of intervention guidance, whilst remaining flexible in order to create the kind of relational space that suited each parent/couple. They prioritised agreed parental goals, negotiated extra sessions to provide support for longer, adapted roles within the relationship to provide what parents felt was the best use of the time, and used therapeutic techniques where they could be useful in a short time-frame. Like relationships with young people, relationships with parents followed unique courses. At the same time, workers identified common themes, also referenced by parents, of distress and shock following disclosure, emotions of guilt and shame, disruption of family relationships, feelings of loss of confidence as parents/mothers, and helplessness in understanding and dealing with the changes in their children post-abuse. The joint commitment of parents and workers to children's recovery and future, the shared joy and hope inspired by young people's reported and observed progress, helped maintain the parent-worker relationships.

10.1.5 Research question 6: What are participants' views on how the relationship helped them change?

It is evident that young people and parents felt they were in a different place when the intervention concluded. Change represented for all involved the purpose of the relationships established in the context of the therapeutic intervention. Workers and service users thought that the relationship contributed to change – that being in a different place would not have been possible without it: from the perspective of those involved, the possibility for change grew from the relationship.

Young people felt that their everyday lives were different in a good way because of the work they did with their therapists; three young people felt their whole lives had changed for the better. Their accounts indicate that they believed change would not have occurred without their workers.

Change was not something done to them: young people acknowledged their part in shaping their lives and their futures but in partnership with their workers. Some changes represented small shifts that made a big difference, such as the breathing exercises which young people learned from workers and utilised in their everyday spaces. These were small changes, borne of activities agreed within the therapeutic relationships, created through dialogue and action, and having the potential for long-lasting change affecting young people's relationships outside the therapeutic space.

Practitioner perspectives were compatible with young people's accounts and provided additional insight into therapeutic change. The drama of change was relayed by practitioners who described gradual shifts, sudden breakthroughs, and periods of no change at all. Change in young people from practitioners' perspectives could also be elusive, subtle and difficult to define with precision. Practitioners were helped in their assessments of change for young people by communication with parents and parent practitioners who were able to validate change witnessed by workers in their conversations with young people. Where this did not happen, practitioners reported having only their own professional judgement and skill plus what young people reported to guide them.

Parents noticed positive changes in young people at home and in other relationships, and heard about change from practitioners. They saw change in behaviour, lessening of symptoms, growth of confidence, and improved relationships with others. Young people's progress engendered hope in parents and therefore change in their outlooks. Parents' reports of change in themselves varied as they were primarily concerned with their children's recovery, but all viewed their workers as helping them move forward, and their children's workers as exceptionally helpful. Parents who discussed with their workers emotions of guilt and shame reported that dialogues helped them shift their views of themselves as bad or failing parents/mothers. These parents were seen, and described themselves, as stronger, more confident, feeling better. Parent practitioners, finally, demonstrated consistency with

parent accounts in noting dramatic change in some, and subtle benefits for others. Practitioners viewed their role of offering hope to parents, helping them see that they and their children could move on, and talking about the future as a better place useful in promoting change in parents' outlooks.

10.2 Unique contribution to knowledge

This study is the first to look explicitly at children's views of relationships developed in therapy after sexual abuse, and to have coordinated perspectives of three participant groups as described. The combined views of young people, parents and practitioners provide a more complete picture of relational processes than is found in studies which examine perspectives of a single group. In addition, the study is distinctive in its focus on *TASC* items in combination with rich qualitative data that reflect lived experiences within this population. Most research has either measured therapeutic alliance, or investigated relationships using qualitative methods, but not both. Finally, the approach is novel in including exploration of relationships between practitioners and non-abusing parents involved in a carer intervention.

The study supports findings of other research, and adds new knowledge to the study of professional relationships with sexually abused children. In support of existing research, the findings depict the value of relationships in therapy regardless of therapeutic approach, demonstrate empirically how relationships can be used to support change for young people in this context, and support the movement towards relationship-based practice in social work. Young people and practitioners expressed views on practitioner and process characteristics which concur with outcomes of other studies, in particular the importance of trust for young people who have been betrayed through sexual abuse. Findings also support research highlighting the depth of impacts on non-abusing parents, and endorse their appeals for services specifically designed to meet their needs.

The study has added new insight into the needs of young people for relational safety incorporating trust, confidentiality and privacy. It has shed light on practitioner skills, approaches and characteristics which respond to those needs, and illuminated the responsive symmetry in relational work of the expression and understanding of needs and wishes. The study clarifies change processes through young people's accounts of transferring learning and progress made within the relationship to their everyday spaces through practice and application. It reveals the importance for both parents and children of acknowledging progress, and illustrates how such knowledge both strengthens the relationship and provides hope and motivation to continue. The study has provided new information on the evolutionary nature of goal-setting in therapeutic work with young people. Finally, the study illustrates from parent perspectives the variation and value of non-therapeutic but professional, empathic, and supportive relationships, and highlights how positive change can occur within such relationships in a relatively short space of time.

The model in *Figure 41* has been used throughout to help illustrate the themes developed from participants' accounts. Whilst young people and their workers occupied a special, safe, relational space which did not include parents and their practitioners, they were involved and part of the wider therapeutic process focused on children's healing. The therapeutic space was cocooned but not disconnected from impacts of participants' everyday spaces. It was recognised by all that the purpose of creating the space was to enable young people and their families to leave it behind when it was no longer necessary.

Figure 41: Therapeutic Space Model

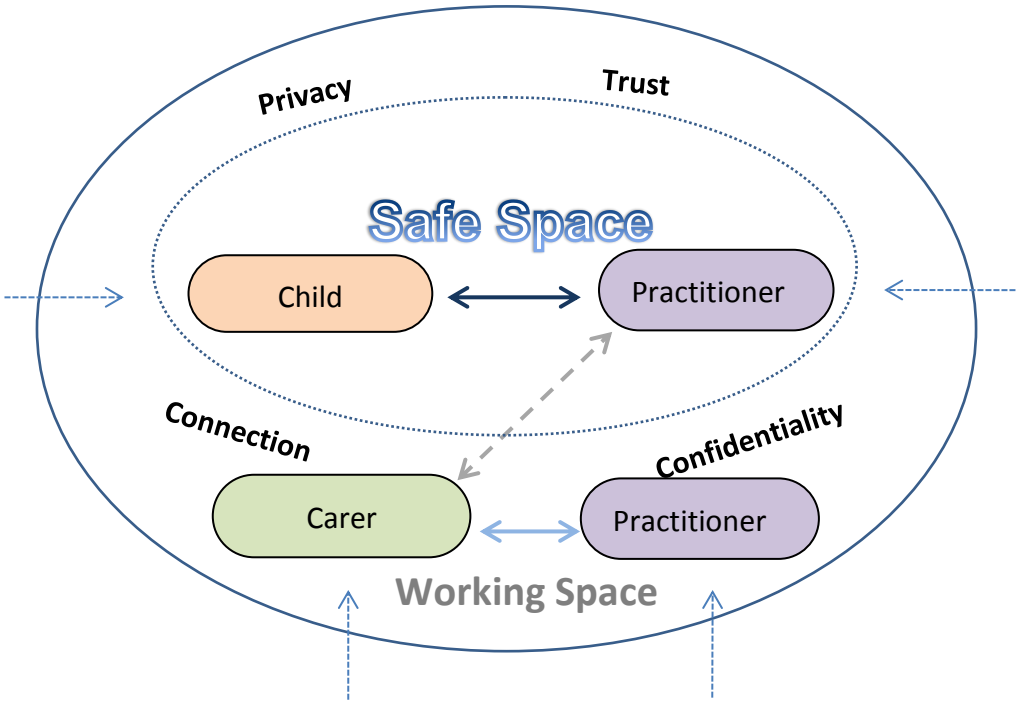
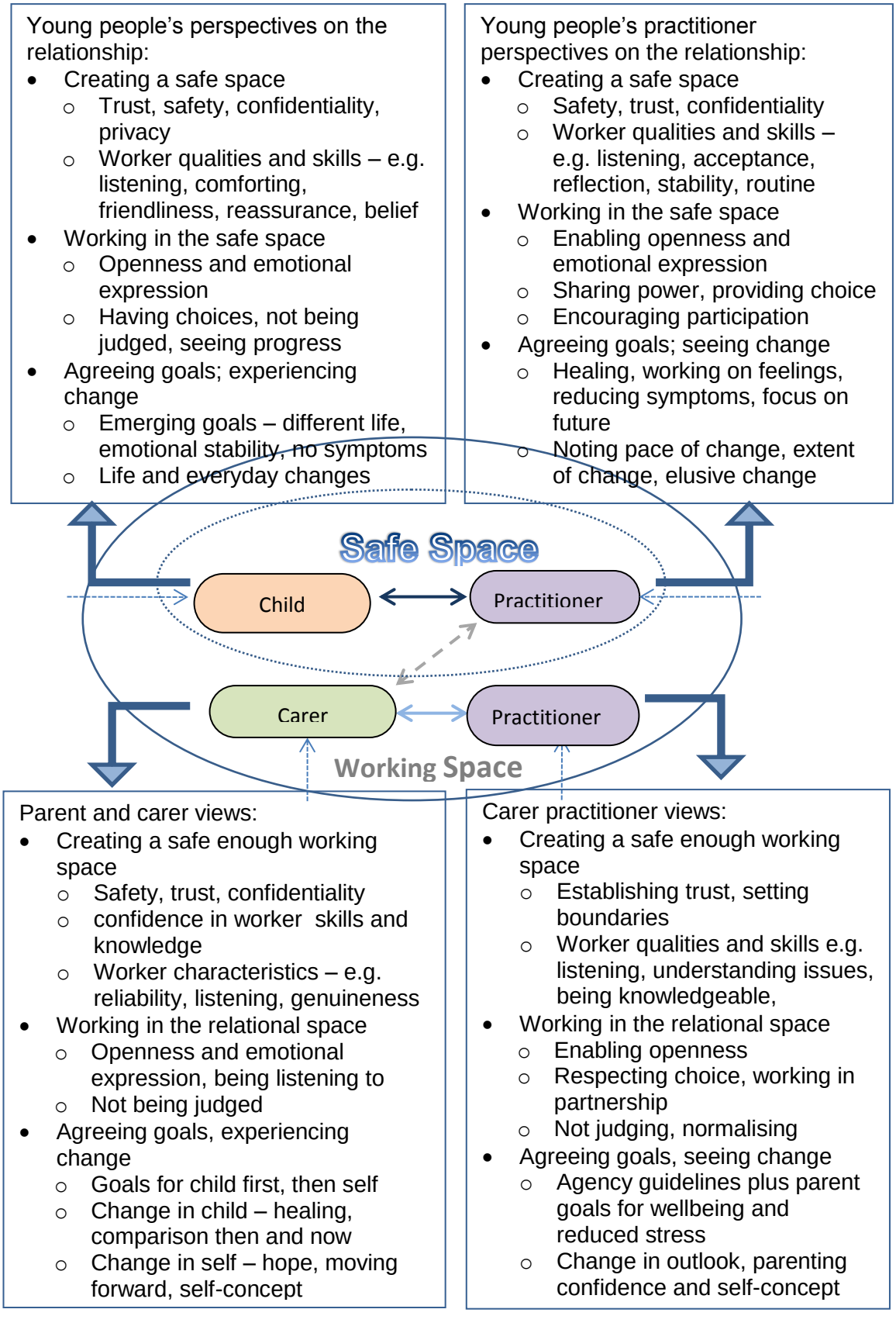


Figure 42 briefly summarises the findings of each chapter in relation to the model above.

Figure 42: Model of relationships developed in therapy, summary of themes



10.3 Strengths and limitations of the research

This study is limited by sample size and the inescapable bias in a sample which is obtained through convenience sampling, gate-keeping and self-selection. As all participants described their working relationships as positive, evidence of opposing perspectives is lacking; additionally not all practitioner views are balanced by child or carer views. Participant accounts describe what they saw as good outcomes, and the study therefore examines the perspectives of those who experienced the therapeutic relationship as strong and for whom there were positive changes. Without defining a sample which includes young people who do not complete the intervention, it might be difficult to find sufficient participants with less positive ratings of therapeutic relationships as they might be more likely to drop out.

The study also cannot speak to people from ethnic groups not represented, and is affected by gender imbalance. Only one male parent was available for interview, and no cases with boys were referred, so findings can only be said to relate to girls. The uniformity of gender is not an uncommon issue in studies pertaining to child sexual abuse where, ironically, gender may be particularly relevant. Gehart and Lyle (2001) note in existing research discrepant views on the importance of gender between client groups and therapist groups and the potential for therapists to be "*affirming gender-based expectations"* (Gehart and Lyle, 2001:445). They report in their study, one participant who had been sexually abused feeling it was easier to disclose her abuse to the female therapist than the male therapist, and also finding that when she did disclose the male therapist "*shot me down"* (Gehart and Lyle (2001:453). It may be that culturally based expectations of gendered reactions to disclosure of abuse coupled with experience of abuse by a male promote unease and fear of adverse reactions such as disbelief or minimisation. Middle and Kennerley (2001) found that in their group of women affected by CSA, eight said the gender of their therapist was important, and six commented that it was easier to talk to a woman.

There are distinct strengths of the study which mediate against the limitations described above and ensure that its findings are generalizable within the boundaries of time and context (Lincoln and Guba, 1985:37) appropriate to the nature and purpose of qualitative inquiry. The strengths of the study are in the co-production of its design with the evaluation team and the Agency, which enables the findings to complement those of the evaluation, fit well within the Evaluation report, and to inform practice in the Agency and others providing similar services. The richness of the data about relational processes from different perspectives, and the inclusion of quantitative data to examine relationships in a different way, help to achieve a level of triangulation of sources and methods which help strengthen the value of the knowledge gained and its applicability in practice. It was a unique approach in which two insider views of children and practitioners could be compared and additional information from involved parents/carers could provide a rich picture of relationships. The opportunity to examine parental views of their relationships and those of their children in depth offers valuable knowledge in a context in which the needs and wishes of parents and carers who have been assessed as "safe" are often neglected. In the context of a large and ever-expanding body of knowledge from practice-based evidence and relevant research, the findings offer important messages, discussed in section 10.5, to practitioners in social work and therapy and to agencies providing services for families affected by CSA.

10.4 **Reflections**

> *"As it is not possible to interpret experience in a vacuum, a frame of intelligibility is needed to provide a context for attributing meaning, and our personal story (self-narrative) provides this frame."* (Parton and O'Byrne, 2000:50)

One of the fascinating, wonderful and challenging aspects of undertaking this study was the symmetry of exploring different perceptions of the same complex relationship from within a relationship. Our encounters were relationships of research in which co-constructed accounts of other relationships were formed. Whilst interviewing children I felt an outsider, and

when I reflected on interviews I recognised different feelings associated with each one: protectiveness, humility, anxiety, relief, gratitude, and admiration. In adult interviews, I felt I was in the position of a kind of insider as a parent and as a practitioner, though not a therapist. As the Parton and O'Byrne quote above suggests, there is always a personal story framing the meaning-making experience. I was always aware that in the real world, we misinterpret, misunderstand, put our own spin on what we see/hear/read, and view the world through lenses which are influenced by our individual experiences, capabilities and temperament and the cultural, social and political environment around us. In real world relationships, we have an advantage of being able to observe communication not involving words. In brief semi-structured interviews, we are largely limited by verbal communication. I was conscious of the limitations of language and reliance on the spoken word, and of my responsibility as a researcher to represent the views of the people to whom I spoke in a faithful and beneficial way. My reflexive questions throughout the process were about whether I had left people in a good place and had understood well enough, how I could represent people's views without distorting them, whether participants would recognise their views in my reconstructions, how readers would understand and respond, and always how I could improve.

Anderson (1992) writes of "*reflections on reflecting"* about his therapeutic work in a way which I found inspiring. He talks of his view of life as himself, his surroundings, and their surroundings all moving continually towards the future:

> "…*the shifts of life around me come by themselves, not by me. The only thing I can do is to take part in them. To take part is to learn to use the repertoire of understandings and actions that have come from the various experiences I have had over the years. What seems to be most important is to learn what I shall."* (Anderson, 1992: 54)

He describes the impossibility of paying attention to everything all of the time, and intuition as "*the state of being open and sensitive to the touches from the 'outside life' and at the same time being open and sensitive to the*

answers from the 'inside life'" (Anderson, 1992:55). This is particularly interesting to me as a social worker as we are so often advised against making decisions based on intuition alone. Anderson talks of patterns of working which "*speak from practice first and thereafter, now and then, stop to discuss and theorize about the described practice"* (Anderson, 1992:55). As I reflect on the process of research and writing, I recognise that this sounds like my pattern also, and that it represents my pattern of practice in many of my everyday spaces. This means that what I focus on, and the theories that attract me and my understanding of them come from my unique combination of "*outside life"* touches and "*inside life*" answers; that my language limitations restrict my ability to say exactly what I think; and that in the future the "*shifts of life around me"* may cause me to change my mind. I have definitely changed during this process, have learned much about change from young people and parents and the practitioners in this study, and they have made me think, often uncomfortably, about my past practice.

The accounts in this study are co-constructed: we created them together. The interviews provide a summary, a retrospective overview of people's views on the nature and quality of their relationships with others. People relied on memory, which can itself be viewed as a relational phenomenon. As an analogy, if we ask someone about their trek from Land's End to John O'Groats at the end of it they may feel elated that they have achieved a goal, relieved to have survived without injury, and boosted by the praise and good wishes from others. They may recall high points and low points, but will provide an overall report coloured by however they are feeling at the time of re-telling, and by their reflections on the moments that stood out. We get from their account an overview from a platform of retrospection. If we asked them at every stage along the way, we might get a roadmap – the view from each point along the way. This would yield a detailed and different, more nuanced view of the journey, and provide more information about what it is like to travel that distance. I have learned from the research process more

than I could possibly write down or remember, and no doubt will remember the high points and try to ignore the low.

Two themes stand out in this experience. The first relates to my constant surprise that people were willing to talk to me, and then how much information they gave. The second relates to how fortunate I was to have those brief relationships and how their stories touched and sometimes surprised me, particularly those of mothers, perhaps because as a mother I could connect with their distress at feeling helpless to make it all better for their children. This is a feeling I remember from social work practice as an experience, shared by colleagues, of being privileged to make connections with people who tolerate intrusion and share parts of their lives.

10.5 Implications for practice

This study has implications for service providers, social workers and other practitioners working with children who have experienced sexual abuse and their families

- Specialist agencies providing services for children affected by sexual abuse should ensure that interventions emphasise relational processes regardless of therapeutic approach. Formal guidance on assessment and intervention structures and process should allow flexibility so that practitioners can adapt to the needs and pace of individual children. Workers in this study valued being able to use their familiar skills and experience within set boundaries. Agencies should also provide appropriate physical environments for work with sexually abused children, ensuring venues which prioritise privacy, comfort and confidentiality which young people said was important to them, and which provide materials suitable for a range of different needs. Both young people and practitioners are helped by having choices over how they communicate, and young people's participation and expression were

encouraged by their surroundings and availability of a variety of resources.

- Agencies providing services for abused children should consider the value for children and parents of providing additional formal support for non-abusing parents to cope with the consequences for their child and themselves of child sexual abuse. Parents may be protective yet at the same time distressed or traumatised by sexual abuse of their children. Parents and practitioners in this study recognised the value of a supportive relationship with a knowledgeable practitioner to advise, provide emotional support, reduce trauma, and importantly, give parents hope.
- For social workers and other practitioners, the joint creation of safe relational spaces with children and young people is key to establishing an environment where communication about change can occur. First impressions are important: professionals working with children affected by sexual abuse should build safety and trust into their relationships from the beginning. Young people commented on the importance for trust-building of having workers who listened without blaming or judging. Active listening and reflective skills, the capacity to "tune in" to young people's moods and feelings, and the ability to communicate genuine care and concern are essential. Early engagement together in activities which encourage the development of trust and help worker and young person get to know each other helps develop relational bonds. If activities are both fun and purposeful they also contribute to an early sense of achievement, which in turn strengthens the bond. Young people respond to human qualities of warmth, niceness, comfort, humour, respect and acceptance and professional skill in providing clear and honest explanations and choice about how to engage.
- Young people in this study understood the concept of confidentiality and its limits. Social workers should give young people age appropriate and honest explanations of confidentiality limits, check that they understand, and then respect the parameters they have set. In this study, young

people valued genuineness, and responded to workers who they believed would keep promises.

- Young people do not want to be rushed. In this study, they commented positively on not feeling pressured and having time to develop a safe space which was their own and where things happened at their pace. Each child is unique and social workers should exercise patience, and be prepared to accommodate to young people's timescales in order to ensure they feel comfortable and feel that workers are there for them. When young people understand the purpose of working together they are able to decide when they feel safe enough to be open about problems in their lives. Practitioners should be clear about purpose and timescales they cannot control so that children have information and choices.
- Young people valued not being questioned about their abuse, particularly early in the relationship. Asking too many questions risks undermining the process of developing trust and the value of working non-judgmentally. Social workers should be sensitive to children's feelings of vulnerability about revealing intimate feelings and details, and mindful of what else is going on in their lives and the other people and processes with whom they are involved.
- Practitioners can facilitate change by understanding the evolutionary nature of goal setting, and by helping children state their own wishes and needs. Young people may not be able to describe goals, wishes and needs at the beginning of a relationship, but this does not mean they are incapable of developing goals which may or may not be the same as those set by adults in their lives.
- Social workers working in family contexts should understand the dynamics of child sexual abuse, not only how it affects young people but how it affects other family members. In relation to parents, whilst assessment of parental protective capacity is important, practitioners should also consider whether parents need support for their own needs. Voices of non-abusing parents have been neglected in research and practice, yet they are the people with greatest responsibility and concern

for their children. It is particularly important for non-abusing parents to hear from practitioners that their children are making progress, that change is possible, that the future includes hope.

10.6 **Further research**

There is always a call to look beneath the surface of process and outcome measurements to hear the voices of those in receipt of services, and despite achieving the aim of gathering participant perspectives, there is much this study was unable to accomplish. It would be interesting to know if young people in other services for children affected by sexual abuse report the same process of relationship building and similar emphasis on safety, trust and confidentiality. There were no boys in the sample, and it is important to hear the perspectives of boys on relationships in therapy and to compare their views with those of the girls. Similarly, only one father was included. Although men were involved in the carer intervention, their views on the relationships they and their children developed have not been sufficiently heard. Also, the findings relate to young people and parents who shared culture in the broad sense of being white British, and who were enabled to follow the referral route to this specific service. Other service users in different cultures might provide a different view of relationships from the inside. Finally, the reports in this study were overwhelmingly positive. It would be valuable to seek evidence related to the implications for young people's and parents' experiences where relationships did not develop so positively in order to maintain the focus on improving services.

10.7 **Epilogue**

Heather summed up the path and her view of her therapeutic relationship in three sentences. Her words are reproduced here as an "I poem".

*Relational process as an "I poem":**

When
I first met her,
I don't think
I really liked her.

Then
I got to know her,
I started to get on with her,
I really liked her.

When
I found out she was leaving
I nearly cried.

She was like one of my best friends

Heather, aged 14

**The "Listening Guide"* (Gilligan et al., 2003)

Sometimes nothing else needs to be said.

11 Appendices

11.1 Appendix A: Information for children

"Me and My Worker" Study

Information for Children

What is this about?

This is a project looking at how children get on with their *Agency* workers. It is part of the research which is collecting information about "*Intervention*". You are invited to take part, because you met with an *Agency* worker in "*Intervention*".

This information sheet might help you decide if you want to take part in the "Me and My Worker" study.

What does taking part mean for me?

If you take part, someone from Durham University called Josie Phillips will visit you to ask you about how you got on with your *Agency* worker.

Josie will ask questions like:

Tell me about your *Agency* worker.

What was your worker like?

What did you think when you met your worker for the first time?

How did you get on with your worker?

There are no right or wrong answers!

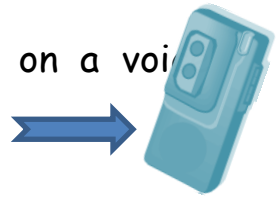
Also, your *Agency* worker will not know what you say.

Do I have to take part?

No, you can choose. You may talk to the person who looks after you if you want some help deciding, and you can ask for more information.

What will we do?

Josie will record what you and she talk about on a voi recorder. No one else, including your worker, will listen to the recording, or know what you say.



How does that work?? When Josie makes notes of your talk with her, she will take out your name, and all the names and places you talk about. It works something like this:

(My name is [redacted]

You will have choices – whether or not you want to have a grown up stay with you, if you would like to take a break, and if you would like to talk, write, draw, or do all of these. Josie would also like to talk to your worker about how they think you got on with them – but your worker will not know what you said! You can say if you do not want Josie to talk to your worker.

You can stop any time you want and you do not have to answer questions if you don't want to.

What happens to the information I give?

What you say will be **confidential** – that means that what you say will not be shared with any other people. But, if you say something that makes Josie think someone is being hurt or is in danger, then Josie may have to let someone else know about that. She will tell you if she is going to do that.

Josie will keep the information you give safe. She is talking with other children and young people and will add all the information together to write a report at the end. The report will be about how people found talking with their *Agency* workers.

Asking questions and talking to the *Agency*

If you have any questions or worries about this, please talk to the person who looks after you. You can also ask Josie any questions about the research.

If you want to complain about any part of this study or make a comment, you can contact the *Agency* through anyone who works there, a volunteer, or your local office. There is a leaflet attached telling you how to get in touch.

11.2 Appendix B: Consent form, children and young people

Consent Form – Children and Young People aged 10 and over

Deciding to take part in the "Me and My Worker" Research

Please read the information provided about the research and think about it before you agree to take part. Please also talk to the person who looks after you about taking part. You will not be able to take part without their agreement.

- You do not have to take part in the research, it is voluntary.
- All information from your interview will be made anonymous. This means no one will be able to identify you, the area you live in, or *Agency* Centre you attended.
- Interviews are recorded, and all information is stored safely at Durham University. Names and other identifying features will be removed from the interviews in transcription, and the original recordings erased at the end of the research.
- All information you give will be confidential and will not be shared with *Agency*. However, if you tell the researcher something that raises a concern that you or someone else may be at risk of harm, then the researcher may have to pass this information on. She will tell you if she is going to do this.
- The information you give will contribute to the report to be written at the end of the research, and will form part of the overall evaluation of *Intervention.* As the researcher is post graduate student, the findings will also be reported in the thesis to be submitted to Durham University

If you agree to take part

If you agree to take part and for researcher to use the information you provide, please read and complete the form on the next page. You will be given a copy of this form.

Your involvement in the "Me and My Worker" research

I (name)_____have read and understood the information sheet provided.

I agree to the following (please tick):

☐ To take part in the "Me and My Worker" research

☐ For the researcher to use my exact words where appropriate in reporting on the findings of the research but without using my name

☐ For the researcher to see the scores from my *Therapeutic Alliance Scale*

☐ For the researcher to interview my worker

I understand (please tick):

☐ I am free to withdraw from the research at any time.

☐ The information that I give will be treated confidentially.

☐ All information that I give will be made anonymous. My name will not appear in any reports or papers produced by the researcher.

Name: _____

Signed: _____ **Date:** _____

11.3 Appendix C: TASC, worker version

Therapeutic Alliance Scale for Children - Worker Version
TASC-r (Worker Form) Revised

Instructions:
The statements below are about your relationship with the child you are working with. Please circle the number corresponding to your opinion for each item.

---

1. **The child likes spending time with you.**

1	2	3	4
Not at all	A little	Mostly	Very much

2. **The child finds it hard to work with you on solving the problems in his/her life.**

1	2	3	4
Not at all	A little	Mostly	Very much

3. **The child considers you to be an ally.**

1	2	3	4
Not like the child	A little like the child	Mostly like the child	Very much like the child

4. **The child works with you on solving problems in his/her life.**

1	2	3	4
Not like the child	A little like the child	Mostly like the child	Very much like the child

5. **The child appears eager for the sessions to end.**

1	2	3	4
Not like the child	A little like the child	Mostly like the child	Very much like the child

6. **The child looks forward to therapy sessions.**

1	2	3	4
Not like the child	A little like the child	Mostly like the child	Very much like the child

7. **The child feels that you spend too much time focusing on problems in his/her life.**

1	2	3	4
Not like the child	A little like the child	Mostly like the child	Very much like the child

8. **The child is resistant to coming to sessions.**

1	2	3	4
Not like the child	A little like the child	Mostly like the child	Very much like the child

9. **The child uses his/her time with you to make changes in his/her life.**

1	2	3	4
Not like the child	A little like the child	Mostly like the child	Very much like the child

10. **The child expresses positive emotion toward you.**

1	2	3	4
Not like the child	A little like the child	Mostly like the child	Very much like the child

11. **The child would rather not work on problems/issues in therapy.**

1	2	3	4
Not like the child	A little like the child	Mostly like the child	Very much like the child

12. **The child is able to work well with you on dealing with problems/issues in their life.**

1	2	3	4
Not like the child	A little like the child	Mostly like the child	Very much like the child

11.4 Appendix D: TASC. Youth version

Therapeutic Alliance Scale for Children – Youth Version
TASC-r (Youth Form) Revised

Instructions:
Please read these statements about your NSPCC worker.
Circle the number which matches best how you think or feel.
There are no right or wrong answers.

---

1. **I like spending time with my worker.**

1	2	3	4
Not at all	A little	Mostly	Very much

2. **I find it hard to work with my worker on solving problems in my life.**

1	2	3	4
Not at all	A little	Mostly	Very much

3. **I feel like my worker is on my side and tries to help me.**

1	2	3	4
Not like me	A little like me	Mostly like me	Very much like me

4. **I work with my NSPCC worker on solving problems in my life.**

1	2	3	4
Not like me	A little like me	Mostly like me	Very much like me

5. **When I'm with my worker, I want the sessions to end quickly.**

1	2	3	4
Not like me	A little like me	Mostly like me	Very much like me

6. **I look forward to meeting with my worker.**

1	2	3	4
Not like me	A little like me	Mostly like me	Very much like me

7. I feel like my worker spends too much time talking about problems in my life.

1	2	3	4
Not like me	A little like me	Mostly like me	Very much like me

8. I'd rather do other things than meet with my worker.

1	2	3	4
Not like me	A little like me	Mostly like me	Very much like me

9. I use my time with my worker to make changes in my life.

1	2	3	4
Not like me	A little like me	Mostly like me	Very much like me

10. I like my worker.

1	2	3	4
Not like me	A little like me	Mostly like me	Very much like me

11. I would rather not work on my problems with my worker.

1	2	3	4
Not like me	A little like me	Mostly like me	Very much like me

12. I think my worker and I work well together on dealing with problems in my life

1	2	3	4
Not like me	A little like me	Mostly like me	Very much like me

11.5 Appendix E: CFQ

Carer Feedback Questionnaire

Unique ID No _____

Today's date_____

You are being asked to complete this questionnaire as the parent/carer of a child who has been receiving the *Agency Care Intervention* service. We would like to know about your experience of the work done with you as a carer.

Your worker and *Agency* managers will not see your answers.

Your completed questionnaire will be sent directly to the researchers from Bristol and Durham Universities who are carrying out an evaluation of *Intervention.* The research team does not have your name or other identifying details.

Question 1

Please tell us how the work with the *Agency* helped you in the following areas. Answer only the questions which apply to work which you did during your involvement with *Intervention*.

For each question you answer, please tick the box which you feel best represents how the carers' sessions helped you, as follows:

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree
Increased my knowledge and understanding about child sexual abuse					
Dealt with my negative feelings about my child's abuse					
Helped me cope with feelings of isolation following my child's abuse					
Dealt with my feelings about the perpetrator of the abuse					
Helped me to re-establish a good relationship with my child					
Helped me understand my child's needs better					
Increased my knowledge about how to protect my child from further abuse					
Helped me to support my child's use of the sessions					

Question 2

What helped your situation especially?

Please give a number to the top three (1 = most helpful; 2 = second most helpful: 3 = third most helpful)

a. The individual sessions with the worker. ☐

b. The information given by the *Agency* service. ☐

c. My relationship with the worker. ☐

d. Joint sessions with my child and the worker. ☐

e. Support from people outside the *agency*. ☐

f. Seeing my child make progress ☐

g. Other. *(Please tell us what this is below:* ☐

Question 3

Please tell us about the relationship you had with your *Agency* worker. For each question you answer, please tick the box which you feel best represents your relationship with your worker during the carers' sessions:

	Strongly agree	Agree	Neither	Disagree	Strongly disagree
a. My worker and I agreed on the goals of the work					
b. My worker and I agreed on what we did in our sessions together					
c. My worker and I trusted each other					
d. I had confidence in my worker to help					

Question 4

Please add any other comments you have about the help you received at *Agency:*

Your comments:

Thank you for completing this questionnaire.

11.6 Appendix F: topic guide, young people

Children have a choice whether they want their carer present.

1. **Tell me about your *Agency* worker**.

2. **What was it like meeting your *Agency* worker for the first time?**

3. **What kinds of things did you do when you met with *(name)*?**

4. **What was it like talking to your worker about problems in your life? (What was it like working with your worker on problems in your life?)**

5. **Were there times where you enjoyed spending time with your worker more than other times? Less than other times?**

6. **What was it like finishing with *(name)*?**

7. **Looking back, how much did you like spending time with your worker? How was this time special?**

8. **How much did your worker help you?**

   Prompts:

   - How did your worker help you with what you wanted to change in your life?
   -

9. **If you could change something about your worker, what would it be?**

10. **Someone you know is going to go to *Agency* and will be working with the same person you did. They want to know a bit about how you got on with her/her. What will you say to them?**

11.7 Appendix G: Topic guide – Safe Carers

Introduction – explain that the questions will relate both to the relationship parents had with their own NSPCC worker, and their observations and perceptions of the relationship their child had with her/his own worker.

1. **Tell me about the relationship you and your NSPCC worker had.**
   - How often did you meet? Was your work individual, jointly with your child or both? How did you get on with the worker?

2. **What was it like meeting your NSPCC worker for the first time?**
   - When was your first contact with your worker? What were your first impressions - what did you think/feel when you met for the first session? What were your expectations?

3. **What was it like talking to the NSPCC worker about problems related to your child's abuse?**

   - What were the goals? What kind of work did you do? How did you and the worker decide what the goals/aims of the work were?

4. **Do you feel you achieved what you wanted in working with your NSPCC worker?**
   - How did the worker help you achieve the goals of the work?

5. **How was your relationship with your worker important to achieving your goals? *And*: How was your relationship with your worker important to your child's progress?**
   - How did your relationship help the therapy progress? If you had a good relationship with your worker, did that affect how your child progressed?

6. **Finally, tell me about the relationship your child had with their worker.**
   - How did they get on together? How do you know that? How would you describe the relationship?

Do you have any questions or anything else you would like to say?

At the end of interview, neutral topic, thank you, and voucher

11.8 Appendix H: Topic guide, Practitioners – Young People

1. **Tell me about your relationship with this child/young person.**

    - How would you describe the relationship? How easy/difficult was it to form a relationship with this child/young person? How long did it take? What was it like meeting this child/Young person for the first time? What were important characteristics of your relationship? How did it change?

2. **What was it like working with this child/young person about the problems in their life?**

    - What made it easy or difficult working to this child about their problems? How well did they engage in the work? How do you think the relationship you had helped/hindered your work on this child's/young person's problems? Were there particular tools/techniques that worked better than others?

3. **How well do you feel you achieved the goals for this child/young person?**

    - Did you and the child/young person have common goals? Were you confident/optimistic about helping the child to change/achieve therapeutic goals?Do you think the relationship you had with the child/young person helped them change?

4. **Describe your relationship at the end of the intervention.**

    - How was it at the end, what had changed? What do you remember most about working with this child/young person?

At the end of the interview, ask if they have any questions or anything to add, return to a neutral topic, thank the practitioner for their time.

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